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**SOCIAL CLASS AND THE THERAPEUTIC RELATIONSHIP:**

**THE CLIENT'S PERSPECTIVE:**

**To what extent do perceived differences in social class  
between client and therapist impact upon the therapeutic  
relationship?**

**A qualitative study using a questionnaire survey.**

Dissertation submitted to the University of Chester for the Degree of Master of Arts  
(Counselling Studies) in part fulfillment of the Modular Programme in  
Counselling Studies

**MAY 2016**

## ABSTRACT

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The inequalities in society are often mirrored within the therapeutic relationship, particularly for those therapists working in the NHS or for charitable organisations, where therapists are often middle-class and clients working or lower-class. The aim of this research was to explore, using a questionnaire survey, clients' perceptions of the impact of social class and whether, and if so how, perceived social class disparities impacted the therapeutic relationship. Forty-five completed questionnaires fulfilling the inclusion criteria were returned. Using a quasi-phenomenological approach and Thematic Analysis, four primary themes were identified: 1) Perceptions of own social class; 2) Social class as a facilitative aspect of therapy; 3) Negative impact of social class on therapy; and 4) Clients perceptions of their therapeutic relationship. Regardless of social status of the client or their therapist, social class similarities and disparities were found to both help and hinder the therapeutic relationship. Despite many respondents believing social class to be an irrelevant factor within their therapeutic relationship, this study illustrates that social class was a silent but powerful force affecting clients' feelings of equality, which were often ignored. Though many respondents felt intuitively understood and experienced a more effective therapeutic alliance when perceiving client/therapist social class similarity, there was a danger that therapists could assume too much and/or collude with their clients. The findings also show that where there was social class disparity, though the quality of the relationship, and in particular empathy, were found to be crucial, the explicit recognition and acknowledgement of this disparity were shown to have a positive impact on the client, improving equality, increasing rapport and enabling greater psychological growth. For a client to take full benefit from therapy therapists *must* recognise the importance of social class and classism and the impact these have upon the therapeutic relationship, and be prepared to attend to these dynamics when appropriate.

## DECLARATION

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The work is original and has not been submitted previously in support of any qualification or course.

Signed: Alison Trott

Dated: 2<sup>nd</sup> May, 2016

## ACKNOWLEDGEMENTS

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I would like to acknowledge the following people who have supported me throughout my research:

My parents, Shirley and Jeff, and my sons, Nick, Chris and Andrew, who have tolerated all of my highs, but particularly my lows, and have stood by me and encouraged me on this, sometimes, difficult journey.

To my dearest friend, Sara, and my study buddy, Sabina, who have been so patient and provided me with endless encouragement and support.

To my colleague at work, Jo, who has listened patiently and enabled me to make sense of my ramblings.

To my supervisor, Andrew, who reignited a flame within, whose faith in me has carried me forward when my faith in myself has been lacking, and who has provided me with inspiration, wisdom and guidance throughout all the challenges in my completion of this dissertation.

To my tutor, Rita, and all the peers on my course whose support, friendship and laughter have made this course so memorable.

And last, but not least, to the respondents without whom this dissertation would not exist and who have left me a lasting legacy – I was *class-blind* but now I see.

My heartfelt thanks to you all.



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## LIST OF ABBREVIATIONS

BACP	British Association for Counselling and Psychotherapy
TA	Thematic Analysis
JWB	Just World Beliefs
CCM	Constant Comparative Method
IAPT	Improving Access to Psychological Therapies
NHS	National Health Service
BBC	British Broadcasting Company
ONS	Office for National Statistics
SOC	Standard Occupational Classification
n.d.	No Date
Resp.	Respondent
R	Respondent
T	Therapist
SC	Social Class
LSC	Lower Social Class
USC	Upper Social Class
MC	Middle Class
LMC	Lower Middle Class
UMC	Upper Middle Class
WC	Working Class
UWC	Upper Working Class
n	Number

**NOTE:**

The term therapist is used synonymously throughout this dissertation to cover counsellor, psychotherapist, psychologist and therapist, whether qualified or trainee.

The term therapy is used synonymously throughout this dissertation to cover counselling, psychotherapy, psychology and therapy.



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# 1. INTRODUCTION

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*'No person, I think, ever saw a herd of buffalo, of which a few were fat and the great majority lean. No person ever saw a flock of birds, of which two or three were swimming in grease and the others all skin and bone.'*

Friedrich Engels, German Socialist philosopher, collaborator of Karl Marx (1820-1895)

## 1.1 Background

Having undergone personal therapy as a necessary requirement during my counselling training, what became apparent was the inequality of social structural positions between therapist and client. As a vulnerable client, my first experience of personal therapy proved extremely distressing, reinforcing my own feelings of powerlessness and inferiority. I assumed my therapist was upper-middle-class due to her home, car and oration. How could this person truly understand what it was like for me, with working-class roots, living as a single parent on benefits? I could not connect with her and, needless to say, I did not return.

Now, as a therapist working in the National Health Service (NHS) in a deprived part of Wales, I regularly see clients with chaotic backgrounds and complex needs, often as a result of poverty (ONS, 2011; Piff, Stancato, Martinez, Kraus & Keltner, 2012). However, I believe my own working-class background, together with being class-conscious, enables me to connect with clients more fully than might be the case were I *'class-blind'* and from a more affluent milieu, a point echoed by Mitchell and Namenek (1970). But, as therapists, how class-conscious are we? And, more importantly, how can we use our own class-consciousness to engage effectively with our clients, regardless of differences/similarities in social class?

Historically, white British culture was hierarchical with three main classes: upper, middle and lower, though this is often further divided (Barrow, 2013; CliffsNotes, 2016; Hoyer & McInnes, 2009; Smith, 2010). Those further up the social class hierarchy are usually more privileged and have more rights, with those lower down being more oppressed, deprived and disadvantaged (Jun, 2010; Smith, 1995). It is also well recognised that social class has a major impact on life, with those in the lower-classes being prone to increased physical and mental illnesses, reduced life expectancy, a lack of opportunities and limited choices (ONS, 2011; ONS, 2015).

This inequality in society is often mirrored within the therapeutic relationship: it has been asserted that therapy itself is rooted in white, Western, middle-class values (Liu, 2001; Ryde, 2009); with therapists most likely being female and middle-class and clients being generally poorer, more dependent, less socially supported, and having complex needs (Proctor, 2006). The current climate of increasing austerity has seen the closure of many government-funded and charitable counselling organisations, widening the gap between those higher up the social class hierarchy and those lower down. The differences between therapists and clients are particularly evidenced within the NHS, with a greater percentage of working-class clients being seen through primary care and The Improving Access to Psychological Therapies service (IAPT) [Miles, n.d.], possibly as counselling in doctors' surgeries is provided 'free-of-charge'. However clients using these services are experiencing increasingly long waiting-times, little or no choice of therapy/therapist (The We Need to Talk Coalition, 2010), and with the most deprived clients terminating therapy prematurely (Miles, n.d.). Indeed, a letter in The Guardian newspaper (Meikle &

Campbell, 2015), signed by over 400 therapists, claims that recent government policies penalise and punish the disadvantaged.

## **1.2 Rationale**

It is widely accepted that the therapist-client relationship is the most important aspect of therapy (Knox, 2008; Mearns & Thorne, 2007; Merry, 2002; Rogers, 1951; Schmid, 2001), but other key factors also play a role *viz.*: race, culture, gender, age sexual orientation and class (Lago & Smith, 2010). Whilst much has been written about the impact of the first five factors on the therapeutic relationship, little research attention has been paid to social class, and it remains one of the most elusive and least understood variables within therapy. I am aware of how these other factors interrelate with social class on many levels and it could be argued it is difficult to extricate one from the other due to an individual's worldview (Liu, Ali, Soleck, Hopps, Dunston & Pickett, 2004), however, for the purposes of this study, social class will be the sole focus. Furthermore, the studies into social class that have been carried out, important as they are, were either limited to a small number of participants (Balmforth, 2009; Thompson, Cole & Nitzarim, 2012), or were taken from the therapists' perspectives (Ryan, 2006; Smith, Mao, Perkins & Ampuero, 2011).

As therapists, we are not blank slates, and a client and therapist's initial impressions of each other can impact upon the therapeutic relationship with prejudicial attitudes affecting the outcome (Balmforth, 2009; Beckham, 1992; Ryan, 2006). Regardless of obvious external aspects *viz.*: home, car, neighbourhood, class differences and similarities are apparent through more subtle factors *viz.*: accent, language,

appearance and manner, reinforcing both the client's and the therapist's internalised classism (Holman, 2014). Moreover, feelings of inequality (Ryan, 2006) may be intensified resulting in poor therapeutic outcomes (Chalifoux, 1996).

For some people, social class and class-related issues can be a struggle; for others, social class is rarely, if ever, considered. Liu (2013) posits individuals as inhabiting one of various social class- and classism-consciousness levels, and stresses that to some degree social class and classism are pervasive throughout everyone's lives. Could it be that those therapists/clients with little or no social class-consciousness are unaware of differences in social class within the therapeutic relationship? And, could it be that those who have suffered some form of classism are more acutely aware of social class disparities between therapist and client?

Although this study does not set out to specifically answer these two questions, it may shine light on whether they have a bearing on whether differences in social class between client and therapist do indeed impact upon the therapeutic relationship.

One could argue then that client/therapist social class similarity is more conducive for effective therapy. Even 2000 years ago Aristotle hypothesised that individuals who are similar to one another tend to be attracted to those who are similar (Aristotle, 1984), and psychological research in the 20<sup>th</sup> century demonstrates that he was generally correct (Berscheid & Hatfield, 1969; Byrne, 1971; Byrne, Clore & Smeaton, 1986; Tesser, Millar, & Moore, 1988; Yeong Tan & Singh, 1995). But is

this the case within the therapeutic relationship? Does social class similarity between client and therapist improve the effectiveness of therapy?

### **1.3 Aims and Objectives**

This research aims to explore clients' perceptions of social class and whether, and if so how, perceived social class disparities between client and therapist impact upon the therapeutic relationship. More specifically:

- To find out whether perceived social class disparities between client and therapist impact upon the therapeutic relationship, and if so, how these are experienced.
- To find out how, and in what ways, clients judge their own and their therapist's social class.
- To discover how equal clients feel in relation to their therapist both at the beginning and end of therapy and whether this has anything to do with social class. If so, I want to explore what affected the change.
- To find out how important it is to the client that their therapist is of the same social class, and how they think this might affect their therapeutic relationship.
- If social class *does* impact on the relationship/outcome of therapy, how might this be addressed?

### **1.4 Summary**

My hope is that the findings from this study will enable therapists to better understand the impact of social class within the therapeutic relationship, thereby facilitating more positive therapeutic outcomes.

## 2. LITERATURE REVIEW

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*'Society as a whole is more and more splitting up into two great hostile camps, into two great classes directly facing each other — Bourgeoisie and Proletariat.'*

(Taken from the Manifesto of the Communist Party, Marx & Engels, 1848)

### 2.1 Introduction

A thematic review of the literature was undertaken which, due to the nature of social class, proved to be both complex and multidimensional. Literature was read and re-read and topics relevant to the research question were identified and coded. Codes were then assembled into meaningful groups and themes constructed (Braun & Clark, 2012). McLeod (1994) describes the thematic approach as one that can bring order and organisation to the material.

### 2.2 Literature Search

Literature was found using various computations of key words from a variety of sources including hard and electronic books and journals, and database search engines (Appendix A).

In order to broaden the search Boolean operators were used, as suggested by Brettell (2008). Using the snowball technique, recommended by Burns (2010), the references sections in many of these articles were used to further enhance the search.

The main themes arising from reviewing the literature on social class and the therapeutic relationship were:

- 2.3 Contextualising and defining social class
- 2.4 Class identity
- 2.5 Class similarity/dissimilarity
- 2.6 Class and the therapeutic relationship
  - 2.6.1 Power/inequality
    - 2.6.2 Relationship quality
    - 2.6.3 Initial impressions/assumptions
    - 2.6.4 Language
    - 2.6.5 Dress/appearance
    - 2.6.6 Therapist social class self-disclosure

### **2.3 Contextualising and Defining Social Class**

Though many authors strive to define social class, including Liu and colleagues (2004) who have identified over 400 terms to describe class, hierarchy or socioeconomic status, there is no one clear definition. However, the concept of social class as 'A set or category of things having some property or attribute in common and differentiated from others by kind, type, or quality' (Oxford Reference, n.d.) dates back to the Romans. The word '*class*' is etymologically derived from the Latin word '*classis*'; the six orders Romans were divided into for taxation purposes (Seabrook, 2002). From the Industrial Revolution to the mid-20<sup>th</sup> century, British class structure was divided into three main distinctions: upper, middle and working/lower (Nesbit, 2006). For the purposes of this study I have used the following categories (Barrow, 2013; CliffsNotes, 2016; Smith, 2010):



- **Upper Classes** – tend to consist of people with inherited wealth, many of who have aristocratic titles. This group has significant social and political power and privilege, and often controls the resources by which others earn a living.
- **Middle Classes** – the majority of the British population including professionals, academics, business owners – the ‘white collar’ workers. Often educated to at least degree level and rely on their earnings to support themselves. Have more autonomy, control and economic security than their working-class counterparts. Sometimes subdivided into upper-middle, middle-middle and lower-middle depending on wealth and prestige.
- **Working/Lower Classes** – tend to consist of minimally educated ‘blue collar’ workers/labourers with little opportunity of career advancement, little or no economic wealth, lacking in power or prestige, and often work to support those higher up the social scale. Sometimes subdivided into upper-working (skilled) and lower-working (unskilled). Those in the lowest class are often in poverty and struggling to support their basic needs.

Recently, The Great British Class Survey (Savage, et al., 2013) took a multifaceted and subjective approach to social class, identifying seven different classes, only two of which conform to older sociological models of the middle- and working-classes. This may be due to the blurring and fragmenting of traditional class boundaries (Milner, 1999; Savage, et al., 2013) accounting, perhaps, for the difficulty in defining class and highlighted within much of the psychological literature, particularly since the turn of the millennium (Ballinger & Wright, 2007; Balmforth, 2009; Diemer,

Mistry, Wadsworth, López & Reimers, 2012; Isaac, 2012; Kearney, 2010; Liu, 2011; Rose, 2004).

Research carried out by psychologists during the last century commonly employs objective indices *viz.*: income, education and occupation (ONS, 2011, 2015; SOC, 1995). However, those in psychotherapeutic/sociological fields regard social class as being much more subjective and experiential (Kearney, 2010; Kim & Cardemil, 2012; Liu, 2011; Reid, 1989), with class identity shifting depending on the context one is in (Ballinger & Wright, 2007; Lott & Bullock, 2007; Nesbit, 2006).

Issues of social class had faded by the turn of the millennium to the extent that many authors remark on the near invisibility of the poorer classes in psychological literature (Ballinger & Wright, 2007; Gillon, 2002; Hill, 1996; Liu, 2011; Lott & Bollock, 2007; Ryan, 2006; Smith, et al. 2011; Sue & Lam, 2002; Thompson, et al., 2012), and in related areas such as sociology (Skeggs, 2004) and social work (Dominelli, 2002).

More recently however, there has been a growing discourse on social class within the therapeutic relationship. Much of the energy for this research comes from those who identify themselves as having working-class backgrounds (Ballinger & Wright [2007]; Balmforth [2009]; Bottero [2004]; Gaughan [2010]; Liu [2011]; Reay [2015]; Thompson, Cole & Nitzarim [2012]; Walkerdine [2007]), perhaps because the lower-classes are more aware of rank, and the lack of awareness and recognition of privilege by those who have it (Christens, Speer & Peterson, 2011; Liu, Pickett & Ivey, 2007; Totton, 2009).

Moreover, the majority of these studies take the therapists' viewpoint (Ballinger & Wright, 2007; Kearney, 2010; Kim & Cardemil, 2012; Ryan, 2006; Smith, et al., 2011; Walkerdine, 2007), thus supporting phenomenological inquiry. Significantly, only a few studies examine clients' (predominantly working/lower-class) perspectives (Balmforth, 2009; Isaac, 2012; Thompson, et al., 2012): an important consideration claims Paulson, Truscott and Stuart (1999), since clients' perceptions often differ from therapists.

With the exception of Balmforth's study (2009) (one middle- and six working-class clients), none addressed middle-class client views with lower-class therapist, reflecting perhaps the imbalance in therapists being predominantly middle-class (Gaughan, 2010; Totton, 2009). Studies by Ballinger and Wright (2007), Balmforth (2009), Gaughan (2010), and Thompson and colleagues (2012) support this since the majority of participants recruited had a working-class background.

## **2.4 Class Identity**

Despite a willingness to talk about the political aspects of class, Bottero (2004) claims a reluctance of individuals to identify themselves in terms of class - adopting 'defensive' or 'hesitant' attitudes to class labels (Bottero, 2004, p.987). Due to the lack of conceptualisation of social class, Liu (2011, 2013) created a '*Social Class Worldview Model*' to enable professionals to understand how people make sense of their environment, themselves and others in terms of social class and classism. He identifies two elements to this: socialisation messages, and social class-(un)consciousness and classism (Liu, 2011).

Socialisation messages are implicit and explicit interactions about social class, experienced through sociocultural contexts (Jun, 2010; Liu, 2011; Reay, 2005). These messages, which occur from the moment we are born, shape how we respond and interpret our environments (Piff, et al., 2012), influencing our values, behaviours and perceptions, viz.; language, etiquette, material possessions, in order to remain congruent within one's social group (Kraus, Piff, Mendoza-Denton, Rheinschmidt & Keltner, 2012; Liu, 2011). In the process of socialisation we absorb these messages so that they become so much a part of ourselves we do not recognise them (Rose, 2004) until they bump up against an Other – viz. client-therapist. Therefore, a client's socialisation messages may influence how they see themselves (equal/superior/inferior) in relation to a therapist from a different social class (Kim & Cardemil, 2012, p.33). These class differences are part of the structural fabric of our society and mark out differentials in power and influence (Liu, 2011): being above some and below others.

Liu and colleagues (2007) posit that the higher one's social status the less one is conscious of social class: privilege is exercised unknowingly and assumed to be a natural right: several authors term this '*class-blindness*' (Kearney, 2010; Ryan, 2006). Overtime the privileged "insulated worldview is assumed to be universal and ubiquitous, and those not subscribing to this worldview are considered deviant" (Liu, et al., 2007, p.196). Just World Beliefs (JWB), a psychological construct and personal theory of justice in sociology (victim-blaming) supports this theory, informing us that people get what they deserve, and deserve what they get (Lerner, 1980; Smith, et al., 2011). JWB, set up by people in power to eliminate injustice, assigns blame to the lower-classes for their misfortune (Lott & Bullock, 2007; Smith,

et al. 2011). High JWBs are strongly correlated with negative attitudes towards the lower-classes (Furnham & Gunter, 1984; Pope & Arthur, 2009; Smith, et al., 2011).

Thompson and colleagues (2012) explored how low-income clients experienced the process of counselling. The researchers, who identified themselves as middle-class (though two had lower-class roots), found that negative attitudes towards the lower-classes could easily influence both therapist's (particularly those who are class-blind) and client's behaviours towards each other, especially during the initial meeting: for instance, psychologically distancing themselves from each other, thereby undermining the initiation of an effective alliance and obstructing the development of empathy (Smith, et al., 2011). However, there is scant literature on the negative attitudes of middle-class clients with their lower-class therapists.

Moreover, clients seeking therapy may well be victims of classism, either consciously or unconsciously. Classism is, according to Hardiman and Jackson (1997), and Lott (2012), a form of oppression involving domination and control directed towards those with less power, resulting in privilege for One and the disenfranchisement of the Other. However, Liu (2011) argues that classism can be directed, not just downwards, but upwards and within classes. Liu and colleagues (2007) claim all therapists are potentially classist, since verbally orientated therapy-models are based on white societal norms with therapists being middle-class by virtue of their profession, an argument supported by Masson (1993). Furthermore, since class enters into every aspect of clinical work, whether explicitly or implicitly (Walkerdine, 2007), therapists' and clients' levels of social class-consciousness can

significantly impact the therapeutic relationship (Ballinger & Wright, 2007; Balmforth, 2009; Kim & Cardemil, 2012; Ryan, 2006; Thompson, et al., 2012).

## **2.5 Class Similarity/Dissimilarity**

Research from the USA during the 1960s/70s between clients/therapists of different social classes revealed difficulties in maintaining effective therapeutic relationships. However, much of this was with lower-class clients receiving long-term fee-paying psychoanalytic therapy (Carkhuff & Pierce, 1967; Carson, 1967; Carson & Heine, 1962; Festinger, 1957; Heine & Trosman, 1960; Imber, Nash & Stone, 1955; McNair, Callahan & Lorr, 1962; Neimeyer & Mitchell, 1988; Overall & Aaronson, 1963; Rokeach, 1960; Whitehorn & Betz, 1960). Client/therapist social class disparity (including values) was shown to impact therapy in one of two ways: creating either increased tension, as remarked upon by Daniels and Trier (2013), resulting in premature endings (Hollingshead & Redlich, 1958; Rokeach, 1960), or increased dependency prolonging therapy (Pettit, Pettit & Welkowitz, 1974).

One could argue that there must be client/therapist social class matching for effective therapy. Indeed, 2000 years ago Aristotle hypothesised that individuals are attracted to those who are similar (1984), possibly as a result of a biological survival instinct (Ballinger & Wright, 2007), and many studies support this similarity-attraction hypothesis (Berscheid & Hatfield, 1969; Byrne, 1971; Byrne, Clore & Smeaton, 1986; Yeong Tan & Singh, 1995). Carkhuff and Pierce (1967, p.344) found that matching social class (and ethnicity) of therapist and client increased 'depth of self-exploration'. Research by Maluccio (1979) corroborates this: clients felt more positive and were more satisfied with the service the closer they matched

their workers with regard to age, sex and family status. However, Banks (1972) demonstrated that, though there was a tendency towards a greater rapport between similar-classed clients and therapists, it was therapists exhibiting high levels of empathy that produced the more positive outcomes, echoed in work by Wolken, Moriwaki and Williams (1973).

### **2.5.1 Middle-class therapist with working/lower-class client**

When faced with 'higher-class' therapists, studies show clients often felt a range of strong emotions including:

- anger/jealousy over therapists' privilege (Ryan, 2006; Thompson, et al., 2012),
- feeling judged and inadequate due to an inability to conform to dominant middle-class values (Chalifoux, 1996),
- feelings of blame and humiliation (Chalifoux, 1996; Isaac, 2012),
- feeling patronised and insulted when the therapist used their own frame of reference as 'reality' (Balmforth, 2009), or when therapists ignored issues of social class (Balmforth, 2009; Kim & Cardemil, 2012; Thompson, et al., 2012).

These emotions were especially prevalent in therapists who displayed symbols of status (Thompson, et al., 2012), something which may be inevitable when therapists work from home (McGuinness, 2010).

Moreover, working/lower-class clients also tended to experience perceived social class disparities as uncomfortable and disempowering (Balmforth, 2009; Thompson,

et al., 2012), with some clients, feeling inferior to their therapists, deliberately withholding information or withdrawing from therapy as they did not feel understood, or adopting confrontational attitudes (Balmforth, 2009, Chalifoux, 1996); possibly in an attempt to redress the balance of power in their favour (Chalifoux, 1996; Thompson, et al., 2012). Studies also suggest how therapists often ignore the issues and/or the complexities relating to low-income and, as a consequence, therapeutic progress stalls (Balmforth, 2009; Ryan, 2006; Thompson et al., 2012).

Balmforth (2009), Proctor (2006) and Sue and Sue (2015) remark on the difficulties therapists from privileged backgrounds may have in understanding the “social and material realities of deprivation” (Proctor, 2006, p.73), and in understanding working-class values (Lorion, 1974). This may be especially difficult for those therapists who are unaware of their own class values; their middle-class view is reality (Chalifoux, 1996). Furthermore, elements of hostility, wariness and appeasement from both parties, which according to Totton (2009) are always present at the beginning of therapy, may be intensified. The dangers posited are twofold: firstly; therapists unwittingly imposing their own values on those of their clients (Baker, 1996; Barclay, 2013), and secondly; inequality, stigmatisation and classism already experienced by the client being reproduced within therapy (Balmforth, 2009; Strawbridge & Woolfe, 1996; Thompson, et al., 2012; Totton, 2009).

Clients believe the responsibility of voicing class disparity/inequality lies with their therapists, possibly due to feelings of inferiority/vulnerability/incongruence (Balmforth, 2009). Conversely, when social class was explicitly acknowledged,



clients felt their difficulties surrounding being lower-class were understood and the therapeutic alliance strengthened (Chalifoux, 1996; Daniels & Trier, 2013; Kim & Cardemil, 2012; Thompson, et al., 2012). Fanon (2008) argues however, that a genuine intimate relationship is questionable when a client feels inferior.

### **2.5.2 Middle-class client with working-class therapist**

Studies from a middle-class client/working-class therapist perspective, though scarce and as mentioned previously, showed that higher-class clients tended to feel in control within their therapeutic relationships and did not experience differences in class as unempowering (Balmforth, 2009). Other clients, feeling superior, judged their therapists as working-class by their accents and considered them inept (Ryan, 2006). This classist-attitude links into the worldview model suggested by Liu (2013), described above.

## **2.6 Social Class in the Therapeutic Relationship**

### **2.6.1 Power/inequality**

All aspects of relating contain power dynamics (Barclay, 2013). Work by Proctor (2006) defines three types of power: Societal power, Role power and Historical power.

#### **2.6.1.1 Societal power**

In Britain we live in a hierarchical/patriarchal society where the few at the top who hold the power and the wealth keep those without at the bottom (Christens, et al., 2011; Parkinson, 2014; Savage et al., 2013), and where the richest 1% of the world's population own almost half the world's wealth (BBC, 2015).

Qualifications are the symbolic representations of power and rank, with those in authority dealing out the symbols of that power to those in its own ranks, excluding from the rewards those without (Bourdieu, 2010; Lott, 2012; Sennett & Cobb, 1972). What is not valuable is associated with inferior groups. Moreover, “the norms of what is considered mentally healthy” (white, middle-class and male) are also defined by those in power (Proctor, 2006, p.66), leading to suggestions by Pilgrim (1997) of a ‘mental health class,’ owing to increased psychological distress within the lower-classes due to societal inequalities. The evidence showing this link is extensive (Adonis & Pollard, 1998; John-Henderson, Jacobs, Mendoza-Denton and Francis, 2012; Isaac, 2006; Lott, 2012; Maguire & Monsivais, 2015; ONS, 2013, 2015; Pilgrim 1997; Stansfeld, Head & Marmot, 1997), with inequalities increasing feelings of helplessness, dependence and inferiority (Sue & Sue, 2015). Conversely, the higher one’s socioeconomic position, the better one’s physical and mental health, and disability-free life expectancy (Marmot, 2010).

Social class disparity is particularly evidenced within the NHS, with higher-class therapists seeing lower-class clients, and more affluent individuals seeking private therapy (Gofal, 2015). A report, commissioned by Mind (The We Need to Talk coalition, 2010), revealed the majority of people accessing psychological therapies through the NHS had minimal choice in the type of treatment and experienced lengthy waiting times, exacerbating mental distress and powerlessness, something Lott (2012, p.654) describes as “*institutional classism*”: “the maintenance and reinforcement of low status by social institutions that present barriers to increase the difficulty of accessing resources”.

### **2.6.1.2 Role power**

The very act of becoming a therapist, argues Totton (2009), puts an individual into the middle-class category, whatever their class background, though Mitchell and Nameneck (1970, p.225) suggest that those “therapists from [lower-class] backgrounds may retain sufficient class-determined characteristics and behaviours to meet the expectations of lower-class clients”.

Moreover, a power imbalance always exists at the beginning of therapy: the therapist is on his/her own territory and ‘knows how it works’, the client is somewhere new, feels vulnerable/anxious and not in control of events (Balmforth, 2009 p.376; Kearney, 2010). This power imbalance is intensified with a higher-classed therapist (Daniels & Trier, 2013; Proctor, 2002). Furthermore, Sennett and Cobb (1972) maintain that knowledge (which is inherent in our role [Proctor, 2006]) is power and society puts value on knowledge; many clients seeing their therapist as the ‘expert’ however hard the therapist tries otherwise (Chalifoux, 1996; Masson, 1993), exacerbating power imbalances further. To ignore this power, is to use that power (Totton, 2009): “Rank is a drug. The more you have, the less aware you are of how it affects others negatively” (Mindell, 1995, p.56).

### **2.6.1.3 Historical power**

Clients often come to therapy suffering psychological distress due to feelings of powerlessness (Balmforth, 2009; Proctor 2002). Personal histories of power/powerlessness determine how an individual is in a relationship – how they think, feel and behave (Proctor, 2002). An article by Daniels and Trier (2013) indicated that, as childhood memories of powerlessness are reignited, lower-class

clients might inadvertently give their power away to their therapists resulting in a lack of trust and spontaneity in the relationship.

### **2.6.2 Relationship quality**

Much of the research on the effect of social class in the therapeutic relationship has been within the psychodynamic/analytic models (Beckham, 1992; Imber, et al., 1955; Isaac, 2012; Mitchell & Atkinson, 1983; Pettit, et al., 1974; Ryan, 2006; Walkerdine, 2007). Working/lower-class clients generally found these therapists as symbolically representing the elite class (Isaac, 2012), though the high cost of training in these models may mean there are a disproportionately higher number of middle-class therapists within these modalities. In addition, working/lower-class clients often perceived the therapeutic distance and neutrality of therapists as confusing and unnerving (Totton, 2009). Therapists were described as being cold, aloof and un-relating (Sands, 2000), leading to clients' feelings of shame, of not mattering and of being ignored; thus mirroring feelings of inferiority and powerlessness experienced in life (Isaac, 2012). This was the case even when all other signifiers of class were removed (Isaac, 2012).

Whilst the psychodynamic/analytic models could be seen as authoritarian and distant in their approach, the humanistic model, in contrast, was generally seen as warm and engaging, and going beyond the boundaries (Isaac, 2012; Knox, 2008); where clients felt accepted and cared for (Sands, 2000), regardless of class (dis)similarity (Banks, 1972). Rogers' (1951) core conditions (empathy, unconditional positive regard and congruence) were seen as key to an effective therapeutic relationship (Knox, 2008; Thompson, et al., 2012) with clients

experiencing their therapists as people, not just a therapist (Knox, 2008). Conversely, Totton (2009) argues that the core conditions offered by the therapist could encourage clients to feel grateful and indebted.

Whatever the model of therapy employed, a strong working-alliance is well recognised and highlighted by many authors as being crucial in determining the effectiveness of therapy (Bordin, 1979; Knox, 2008; Paulson, et al., 1999; Reis & Brown, 1999; Thompson, et al., 2012). When social class disparity is apparent, development of a strong relationship, with the use of empathy in particular, was key to its success (Ladany & Krikorian, 2013; Thompson & Dvorscek, 2013).

### **2.6.3 Initial impressions/assumptions**

Consciously or unconsciously, people constantly make assumptions and judgments about others based on, *inter alia*: appearance, voice, articulation, dress (Liu, 2011; Walkerdine, 2007). Therefore, how might a client's initial impressions and/or assumptions of their therapist's social class impact upon the therapeutic relationship? According to Kraus and colleagues (2012), unlike other social categories (gender, ethnicity), people do not readily display objective markers of social class to others, *viz.*: degrees, occupational titles. Others purport that from the moment contact is made class similarities/disparities, however subtle, are apparent (Kearney, 2010; Harrison, 2013; Thompson, et al., 2012), and these disparities are exacerbated when therapists work from home (McGuinness, 2010).

Many studies show how clients' and therapists' initial impressions/assumptions of each other, and of inferiority/superiority of rank, can have a significant impact on the

formation of the therapeutic relationship, the effectiveness of therapy, and on the client's willingness to continue in therapy (Beckham, 1992; Ryan, 2006; Smith, et al., 2011; Thompson, et al., 2012). Working-class therapists counselling middle-class clients felt inadequate and traumatised by their clients' initial perceptions (Ryan, 2006). Alternatively, jealousy, due to lower-class clients' initial assumptions of their higher-class therapists, was a theme identified by Thompson and colleagues (2012), leaving clients feeling judged and disconnected when these differences were ignored.

#### **2.6.4 Language**

Use of language is an important variable within the therapeutic relationship (Isaac, 2012; Kearney, 2010; Thompson, et al., 2012). Fanon's iconic quote: "Mastery of language affords remarkable power" (2008, p.18), although aimed at colonialism, reflects the hegemony of oration.

Talking therapies are based on dominant white, Western, middle-class values (Sembi, 2006) which can, according to Holman (2014), discriminate the lower-classes since these individuals are often less skilled in verbalising and self-reflexion than their middle-class counterparts. Moreover, working- and middle-class accents and language-use are powered differently (Mindell, 1995) and utilise different speech patterns: the former using a restricted code, the latter an elaborated one (Bernstein, 1977), with research by Holman (2014) supporting this. According to Kearney (2010), accents and language can impact directly on how each hears the other, particularly where there is social class disparity, with stereotypical assumptions/JWBs being triggered: upper/middle-class oration is often perceived

as 'superior', having status and conveying 'expertness' (Kearney, 2010), whereas regional accents/language are often perceived as inferior (Ballinger & Wright, 2007; Holman, 2014).

Language, therefore, can reinforce both the client's and therapist's internalised classism, thereby influencing one's attitude to the other (Furnham & Gunter, 1984), and thus facilitating or hindering the relationship (Kearney, 2010). It is therefore imperative that therapists have a "sensitive understanding of the predicament of the patient and a willingness to adapt [their] technique" (Bernstein, 1964, p.64), and research by Isaac (2012), showing how therapists' adapt their language-use and articulation to meet those of their clients as a means of establishing an empathic relationship more quickly, supports this.

### **2.6.5 Dress/appearance**

Dress/appearance is itself an emotive topic with much written about professionals dressing appropriately, especially to show competence and trustworthiness (Segal, et al., 2011; Davys, Pope & Taylor, 2006; Karl, Hall & Peluchette, 2013; Turner, Leach & Robinson, 2007). Within psychotherapeutic research, several authors claim that dress and appearance of both parties is a major indicator of class (Isaac, 2012; Liu, 2011; Skeggs, 2011; Smith, 2010). Isaac (2012, p.172) found the 'suited and booted' symbolised being "better than you" and was a formal representation of power, increasing feelings of inferiority/superiority and adversely affecting how one might hear the other, thereby undermining the therapeutic relationship. However, Isaac (2012) also illustrates how therapists under-dressed to match their lower-class clients in order to dissolve power imbalances. Research by Scholar (2013),

examining the role of dress in social-work, concluded that it was important one dressed 'professionally' without emphasising differences in affluence or creating barriers between worker and service-user.

#### **2.6.6 Therapist's social class self-disclosure**

As mentioned previously, therapist's social class disclosure can occur inadvertently through many factors, particularly when therapists work from home (McGuinness, 2010). This can trigger prejudicial assumptions/JWBs creating barriers within the relationship (Harrison, 2013; Thompson, et al., 2012). Historically, therapist self-disclosure has been contentious, particularly within psychoanalytic/dynamic models (Freud, 1958). More recent research shows mixed results (Audet, 2011; Pinto-Coelho, Hill & Kivlighan, 2015) with Somers, Pomerantz, Meeks and Pawlow (2013) suggesting more effective therapeutic relationships can be established when there is careful therapist self-disclosure. However, research also suggests when (if appropriate) therapists explicitly and judiciously disclose their own social class background there is a balancing of power (Harrison, 2013), trust improved (Daniels & Trier, 2013), the therapeutic relationship strengthened (Thompson, et al., 2012), and clients were more likely to discuss their values and lifestyles in terms of social class (Chalifoux, 1996). However, in all these cases therapists were conscious of social class as a factor within therapy.

### **2.7 Summary**

Few studies take the clients' lived experiences of social class within the therapeutic relationship and fewer still from the middle-class clients' position. Client-therapist



social class similarity may itself bring a different perspective. An aim of this study is to further enhance the findings of the research outlined in this chapter.

### 3. METHODOLOGY

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*"We can either have democracy in this country or we can have great wealth concentrated in the hands of the few, but we can't have both."*

Louis Brandeis

#### 3.1 Research Question

Having decided upon a topic to study, the wording of the research question became important. Willig (2001) states that if the wrong question is asked the validity of the findings is undermined. She emphasises that good qualitative research questions tend to ask *how* questions as opposed to *what* questions (Willig, 2001). However, to ask *How do clients perceive ...* assumes that clients would have some perception of social class differences within the relationship. Therefore, the wording *To what extent ...* seemed to frame the question in a way that did not predict the outcome. The methodology is, according to Willig (2001), and Rudestam and Newton (2001), thus determined by the research question.

#### 3.2 Research Philosophy and Design

Social constructionism, as defined by Willig (2001, p.7), "draws attention to the fact that human experience, including perception, is mediated historically, culturally and linguistically", unlike positivism, which believes that "every scientist looking at the same bit of reality sees the same thing" (Robson, 2011, p.20). Given the fact that an individual's social world is strongly influenced by the sociocultural contexts within which they develop (Chalifoux, 1996), social constructionism seemed the most appropriate epistemology for this study. Furthermore, social constructionism purports many '*knowledges*' (Chalifoux, 1996); individuals have their own unique experience and perceptions of social class and how these are perceived to impact

on and shape their therapeutic relationship depending upon one's sociocultural reality (Jun, 2010).

As social class within British culture has moved from being a fairly static construct, with individuals being born into particular roles and knowing their place (McLeod, 2001), to a more fluid society with many social class identities on offer, qualitative inquiry enables clients to have a 'voice', allowing professionals to more fully understand "the construction of that segment of their world that is presented by their clients" (McLeod, 2001, p.4).

Phenomenology (formulated by Husserl, 1927), which informs qualitative research, focuses on how individuals perceive the world (Willig, 2001). Willig (2001) asserts that a transcendental attitude is required in order to identify the true *essence* of human experiencing. The phenomenological approach takes an interest in psychological processes *viz.*: respondents' perception, awareness and consciousness (Rudestam & Newton, 2001), all of which were especially pertinent to the research question. However, in order to achieve this, researchers must '*bracket-off*' their own assumptions and biases that might prejudice the results, a technique known as *Epoché* (Katz, 1987; McLeod, 1994). Recognising how my own experiences of social class could influence my interpretation of the data, there was therefore a need to continually reflect upon my own internal processes and, as McLeod (1994) suggests, I kept a reflexive account throughout the study to aid with this. In addition, hermeneutics (the interpretation of texts to develop an understanding) further enhances the qualitative process. A combination of

phenomenology and hermeneutics is, according to Heidegger (1962), important in order to understand the 'everyday world' of participants.

Since the data gathered was via questionnaires these, to an extent, limited the depth and richness of respondents' experiences than would be obtained from interviews (Blaxter, Hughes & Tight, 2010; Mintz, 2010), for example, but did allow for a wider lens of enquiry with more participants than an interview process would have pragmatically allowed for. A qualitative inquiry using a quasi-phenomenological and hermeneutic approach, focusing on clients' experiences and their perceptions, using language to express their experiences as authentically as possible (Polkinghorne, 1989; Rudestam & Newton, 2001) was therefore felt to be the most appropriate paradigm for my research methodology.

The qualitative element was complemented and triangulated by quantitative data. 'Method triangulation', described by McLeod (1994) as the use of two different data-gathering techniques within the same study, has the advantage of helping validate the findings.

### **3.3 Sampling**

Denscombe (2010) purports two kinds of sampling techniques: probability sampling and non-probability sampling. In probability sampling the researcher chooses their sample knowing it represents a cross-section of the whole being studied. With non-probability sampling the researcher has no prior knowledge of this (Denscombe, 2010). Purposive sampling, a form of non-probability sampling, was used for this study; respondents were selected according to certain inclusion and exclusion

criteria (Willig, 2001) [see below (and Appendix C for full details)]. Generally, the aim of purposive sampling is to recruit an *homogenous* group (Willig, 2001); viz.: all respondents perceiving that social class impacted on the therapeutic relationship. The main disadvantage of using an homogenous sample is the high probability of employing researcher bias: recruiting respondents that support the theory (Audiencedialogue.net, 2014). In the event, maximum variation sampling, another form of purposive sampling, was employed, since a more heterogeneous sample was collected. The goal of maximum variation sampling is to gain a broad representative view of the phenomenon as a whole, thereby achieving a greater understanding (Maykut & Morehouse, 1994): whilst some respondents either perceived social class similarities (as opposed to differences), or did not feel that social class impacted on their relationship, their questionnaires were still felt to be important and contributed significantly to the study, since the research question asked “*To what extent .....*”.

‘Real’ clients from the general population would have been preferred since they would have a perspective that was fresh and unadulterated from counselling knowledge and, therefore, add value and meaning to the study. However, due to complex ethical issues, it was felt that data obtained from trainee therapists who had recently undergone their own personal therapy would provide material as close as possible to ‘real’ clients. Unfortunately, due to the limited uptake, the study had to take a broader approach, with ethical approval being sought again, to include qualified therapists.

Since one of the aims of this study was to gather information from at least 25-30 individuals, interviews with all these were clearly not appropriate for Masters' level research. The sample size was restricted to 50 "to limit the flow of data to manageable proportions" (Sanders & Wilkins, 2010, p.204).

### **Inclusion Criteria**

- Counselling trainees (on at least a Level 4 diploma course or its equivalent and on a supervised placement), qualified counsellors, psychotherapists or psychologists in supervised practice.
- All respondents must have had personal therapy but must not be in therapy at the time of participating.
- The research is to be taken from them in their role as client.
- Counsellors, psychotherapists, psychologists or counselling trainees who have perceived a difference in social class between themselves and their counsellor regardless of whether or not this has impacted upon the therapeutic relationship.
- Counsellors, psychotherapists, psychologists and trainees must have access to personal therapy should something arise from the study that causes them distress.

### **Exclusion Criteria**

- Counsellors, psychotherapists, psychologists or trainees who are currently undergoing personal therapy.
- Counsellors, psychotherapists, psychologists or counselling trainees who are not in supervised practice/on a supervised placement.

## **3.4 Data Collection**

### **3.4.1 Rationale**

Denscombe (2010) asserts that questionnaires are particularly apposite when used with large numbers of respondents, when the information required is relatively brief

and straightforward, and “when there is a need for standardised data from identical questions” (Denscombe, 2010, p.156). Questionnaires enabled the collection and analysis of both qualitative and quantitative data within a single study (Appendix H). The combination of these two paradigms within the same study is a strategy that Flick (cited in Denzin & Lincoln, 2003, p.8) states “adds rigor, breadth, complexity, richness and depth to any inquiry”.

My aim in utilising questionnaires was two-fold:

1. To formulate questions that sought the opinions, views, beliefs and lived experiences of the respondents<sup>(Questions 12-33 - Appendix H)</sup>. Denscombe (2010) suggests that the questions were worded in a way that required the respondents to express their judgement and values on certain criteria.
2. The demographic element of the questionnaire sought to find information about respondents’ age, sex and perceived social-class.

### **3.4.2 Questionnaire design**

Important factors considered when devising the questionnaire were:

- The questionnaire needed to be simple, unambiguous and as inviting as possible (Denscombe, 2010, McLeod, 1994).
- Include only those questions vital to the research (Denscombe, 2010).
- The ordering of the questions was crucial to avoid presumptions and to encourage respondents towards completion (Denscombe, 2010).

A mix of closed- (including nominal and ordinal) and open questions were used.

- Nominal questions involved attaching numbers to named categories<sup>(Questions 13,15,17,19 - Appendix H)</sup>. Nominal questions were measured by counting up the number of times a particular attribute occurred and, according to McLeod (1994), is the basic type of quantification.
- Ordinal questions, using a Likert scale, also involved categories, but these categories were ranked in a clear order (Denscombe, 2010; McLeod, 1994<sup>[Questions 25,26,30 - Appendix H]</sup>).
- Open questions provided the opportunity to gather data reflecting the “full richness and complexity of the views held by the respondent” (Denscombe, 2010, p.165). These were necessary for the phenomenological aspect of the study.

Rudestam and Newton (2001) emphasise the importance of using pre-existing measuring scales to ensure validity. However, measuring scales, such as the Hollingshead Index (Hauser & Warren, 1997; Hollingshead, 1975) and The Cambridge Scale (University of Stirling, 2009), tend to use objective indices. On the other hand, authors such as Adler, Epel, Castellazzo and Ickovics (2000); Liu, (2011); Ostrove et al. (2000); Pope and Arthur (2009), and Singh-Manoux, Adler and Marmot (2003) suggest that when conducting research, use of a subjective method to measuring social-class may be more consistent and robust than using objective indices. The Cantril Self-Anchoring Scale (Cantril, 1965), used extensively in social and psychological research (Adler, et al., 2000; Gallup, 2013; Singh-Manoux, et al., 2003), is a 10-runged ladder upon which individuals place themselves depending on their social class. However, since the literature review demonstrated not only a tendency towards the use in research of middle- and



working-class positions, which the Cantril Self-Anchoring Scale does not employ, together with a reluctance of individuals to categorise themselves in terms of class (Bottero, 2004), I devised a simple scale using 3 main divisions with 2 subdivisions (Hoyer & MacInnes, 2009), specifically asking respondents to place themselves into a category and to think about their response to doing this.

Two disadvantages of using questionnaires, offered by Denscombe (2010) are firstly: pre-coded questions restrict respondents' answers; and secondly; "pre-coded questions can bias the findings towards the researcher's, rather than the respondent's way of seeing things" (Denscombe, 2010, p.160). In an attempt to overcome these difficulties, a box was provided after every closed-question to enable the respondent chance to air any thoughts or feelings they might have had in answering that particular question.

### **3.4.3 Pilot questionnaires**

A pilot study is considered best practise in order to identify and resolve any problems with the questionnaire before its distribution (Denscombe, 2010; van Teijlingen & Hundley, 2001). My aim was to ensure that the questionnaire was asking questions appropriate to the research question, thereby increasing validity (Rudestam & Newton, 2001) and researcher confidence, and to refine procedural matters such as, the ordering of questions (Oppenheim, 1992), and knowing how long the questionnaire took to complete (McLeod, 1994). Knowing the time taken to complete was crucial since this information would either encourage or dissuade potential respondents from completing the questionnaire.

Six peers from my Master's course completed pilot questionnaires and provided me with their feedback. Factors identified as a result of the piloting are given in Appendix E. The questionnaires were amended according to the feedback received.

#### **3.4.4 Collection**

Initially, university departments and counselling organisations were contacted to ask whether they would be willing to display the advert (Appendix D) and, if in agreement, were emailed the advert together with the research pack – this included a copy of the covering letter (Appendix F), the information leaflet (Appendix G) and the amended questionnaire. An advert was also displayed on the BACP Research Noticeboard (Appendix D).

Unfortunately, since these adverts yielded few responses, I placed an advert on both my supervisor's LinkedIn social media site and mine, which provided an opportunity to make contact with a large group of people not necessarily 'known' to the researcher or supervisor. This advert displayed a hyperlink to the questionnaire and information sheet. "*Survey Monkey*" (a specialist questionnaire website, recommended by Biggam [2011]) was used to create and host the questionnaire (Appendix H). This had two distinct advantages:

- 1) Since a number was automatically applied to each completed questionnaire and no identifying demographics were required, anonymity was assured – an important element that Oppenheim (1992) purports is vital, particularly when the subject matter may be sensitive.

- 2) Use of the program's web page features, as posited by Denscombe (2010), to improve its accessibility and appeal.

It was a necessary prerequisite of the study that respondents had previously read the online information sheet and had had the opportunity of contacting me should they have had any questions that needed answering prior to completing the questionnaire.

### **3.5 Data Analysis**

#### **3.5.1 Quantitative data analysis**

This part of the questionnaire took a deductive approach, since the questions asked were based on the findings from the literature review. I did not intend to perform any in-depth statistical analyses, rather my intention was to use the data produced to make some basic generalisations (having coded and grouped the data (Appendix M), as suggested by Denscombe [2010]), and to make use of some basic statistics (Joseph, Dyer & Coolican, 2010), tables, charts and diagrams to explain the data simply and concisely.

#### **3.5.2 Qualitative data analysis**

The knowledge sought from the qualitative element of the questionnaire did not require the intensity of Interpretative Phenomenological Analysis (Smith, Flowers & Larkin, 2009). The Constant Comparative Method (CCM) appeared to be more in keeping with my aims (Maykut & Moorhouse, 1994), however, I felt CCM still went into unnecessary depths of analysis considering the amount of data to be analysed. Thematic analysis (TA), as described by Braun and Clark (2006, 2012), allowed for the emergence of key themes that most appropriately informed the research

question, whilst still allowing for the richness of respondents' experiences to be heard. Due to the fact that TA has clear procedural steps, and is not dependent on specialised theory, such as Discourse Analysis or Conversation Analysis, it has the advantage of being recommended as suitable for novice researchers (Braun & Clark, 2006, 2012; Howitt & Cramer, 2008). In addition, TA is unique in that its technique is suitable across many epistemologies.

Analysing the qualitative data was a cyclical process and involved complete immersion with repeated reading of the data in an active way (Braun & Clark, 2012). This was necessary in order to search for patterns and units of meaning relating to the research question (Braun & Clark, 2012). Themes began to emerge from the content of the data through an inductive process once all the data had been coded and collated (Braun & Clark, 2012).

Having eliminated questionnaires that did not fit my inclusion criteria, I undertook the following steps with the remaining questionnaires:

- Answers to each question were recorded, then read and reread, and initial codes generated along with its quote (Appendix I).
- These codes were again read and reread, and descriptions and interpretations made through immersion into the data (Braun & Clark, 2012).
- The coded data was then clustered into similar/overlapping themes and subthemes (Appendix J), which Braun and Clark (2012, p.63) state is necessary to "reflect and describe ... coherent and meaningful pattern[s] in the data". A '*miscellaneous theme*' included all the codes that could not be placed into a theme at this stage, many of which were later discarded as

being irrelevant to the research question or inappropriate given the limited word count.

- Having created a number of primary, secondary and tertiary themes (Appendix K), the essence of each of these needed to be defined and to address the research question (Braun & Clark, 2012).
- Data was then extracted to quote and analyse. This was interpreted using hermeneutic strategies providing meaning beyond the descriptive in order to uncover respondents' phenomenological experiences (McLeod, 2001).
- Tables were produced at each stage. Appendices I, J, K and M provide extracts of these.

Whilst analysing and interpreting the data I consciously engaged in *Epoché*, in order to investigate without assumptions or imposing meanings too early (Katz, 1987).

### **3.6 Ethical Issues**

As an accredited member of the British Association for Counselling and Psychotherapy (BACP) I abide by its ethical framework, values and personal moral qualities (BACP, 2012 & 2013) in both my counselling practice and my research. In addition, I was also guided by Bond's Research in Counselling and Psychotherapy (2004), and by the University of Chester's Research Governance Handbook, 2012. Ethical approval was sought through the University's Research Ethics Committee and regular research supervision contributed to ensure continued ethical practice.

### **3.6.1 Confidentiality**

Questionnaires were obtained through the specialist survey website '*Survey Monkey*'. All completed questionnaires are completely anonymous. Data was stored in accordance with the Data Protection Act 1998 and the BACP Ethical Framework.

### **3.6.2 Informed consent**

Details of informed consent were given in the Information Leaflet (Appendix G) that was provided alongside the hyperlink to the questionnaire. By submitting the questionnaire, respondents were declaring that they had read and fully understood the information provided, the implications of taking part, and had had the opportunity of asking questions beforehand should they wish.

### **3.6.3 Research integrity**

I have sought to maintain trustworthiness and transparency throughout this study by being meticulous and organised in data management and in the presentation of the findings, together with ensuring a rigorous audit trail (Flick, 2002). Research supervision was undertaken as necessary.

## **3.7 Reliability and Validity**

Although Denscombe (2010) asserts that quantitative, numerical data tends to be objective in that it is uninfluenced by the researcher, there is always debate as to the assumptions made from this data (McLeod, 2001).

Lincoln and Guba (1985) suggest that qualitative research is judged based on its trustworthiness, *viz.*: confirmability, credibility, dependability and transferability. McLeod (1994) advances this further by offering validity criteria including, *inter alia*, contextualising the study, transparency of the research process, research reflexivity and use of method triangulation, elements that I employed within my study.

### **3.7.1 Transparency**

A clear and meticulous audit trail for both data collection and analysis has been fundamental to ensure reliability and validity (Appendices I, J, K, M). The questionnaires and complete paper-trail of the TA are available if required.

### **3.7.2 Reflexivity**

I was aware of how my own experiences of social class disparity might bias the interpretation of data extracted in both the literature review and my own findings (McLeod, 2001). It is well recognised by qualitative researchers that one's own values and experiences can influence the interpretation of data (McLeod, 1994; Mintz, 2010). Therefore, a reflexive journal was kept as a way of bracketing my assumptions and to minimise that risk, thereby enhancing validity (Willig, 2001).

### **3.7.3 Triangulation**

McLeod (1994) suggests employing the technique of triangulation to ensure factual accuracy. Denzin and Lincoln (2003, p.8) purport triangulation as a means of securing "an in-depth understanding of the phenomenon in question" by drawing together data from a variety of practices (Cresswell, 2003) and, rather than a tool of validation, is seen as an alternative to validation (Flick, 2002).

Using the data from both the quantitative and qualitative aspects of the study is a strategy that Flick (2002) claims adds rigor, complexity and depth to any study.

### **3.8 Summary**

I used thematic analysis using a quasi-phenomenological/hermeneutic approach to provide 'a voice' to respondents' experiences and meanings, and through which themes emerged inductively through an active process of generation and construction (Braun & Clark, 2012).



## 4. FINDINGS

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*“Our inequality materializes our upper class, vulgarizes our middle class, brutalizes our lower class.”*

Matthew Arnold (English essayist) (1820-1888)

### 4.1 Introduction

Questionnaires, using a mix of quantitative and qualitative elements, sought to discover how perceived differences in social class between the respondents and their therapists impacted upon the therapeutic relationship. Many respondents offered full and thoughtful responses in the free text boxes, providing rich data for analysis. The findings include both quantitative and qualitative data and these are addressed separately.

Fifty-one questionnaires were completed and a total of forty-five questionnaires analysed. Whilst initial inclusion criteria asked for respondents to consider perceived differences in social class between therapist and client, several questionnaires gave accounts of perceived social class similarities and these were also included as respondents' comments allowed for a full exploration of the research question. Six questionnaires were discounted since respondents were: still in therapy or had never had personal therapy; not a trainee/qualified counsellor/psychotherapist/psychologist; or were not in supervised practice.

The respondents included in this study represent demographically varied social class backgrounds (Figure 1) and all were aware of their therapist having a similar/different social class identity.

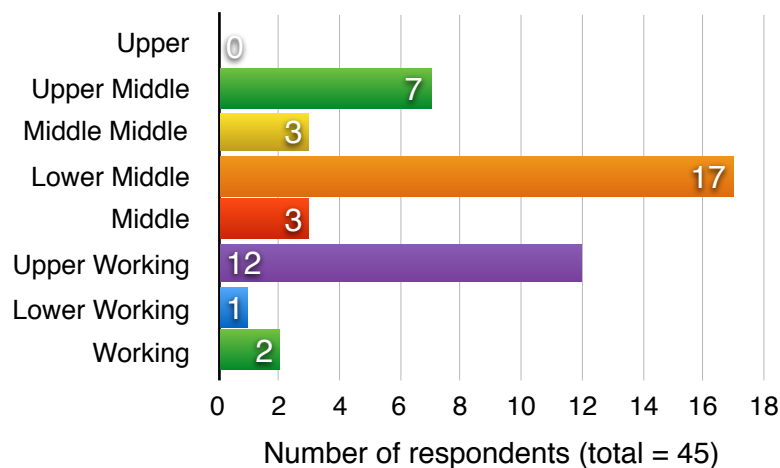
## 4.2 QUANTITATIVE DATA

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Graphs, charts and tables provide basic descriptive statistical analysis of the quantitative data.

- *Appendix L provides respondents' demographic data*
- *See page xi for list of abbreviations used in this chapter*

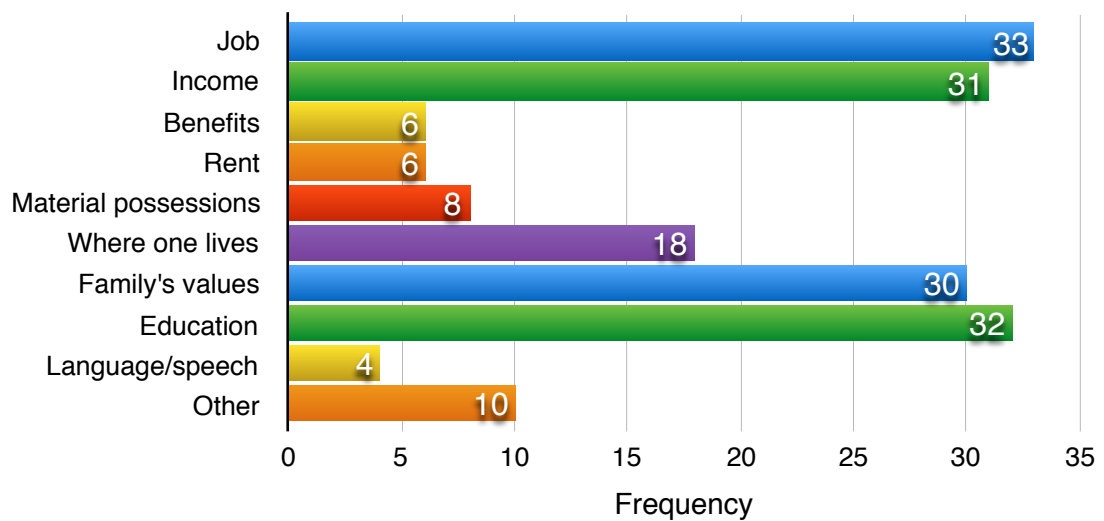
### 4.2.1 Respondents' social class



**Figure 1 – Respondents' Social Class**

#### 4.2.1.1 Determinants of respondents' social class

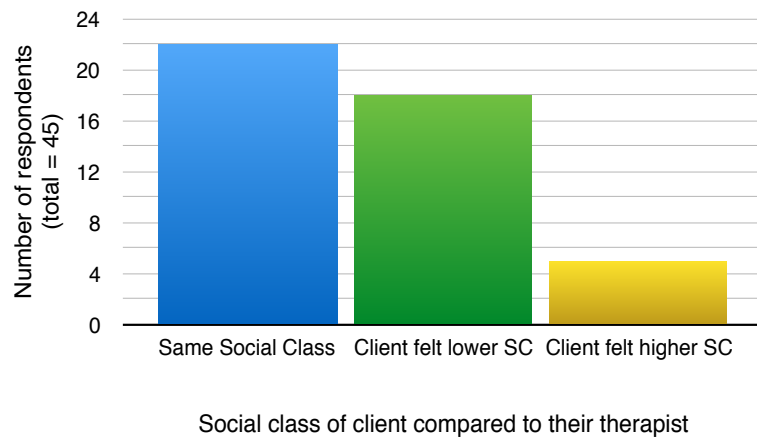
'Other' included, *inter alia*; one's own personal values, culture and spouse's social class.



**Figure 2 – Determinants of Respondents' Social Class**

## 4.2.2 Social class in the therapeutic relationship

### 4.2.2.1 Client/therapist social class similarity/disparity



**Figure 3**

#### 4.2.2.1.1 Judging therapists' social class

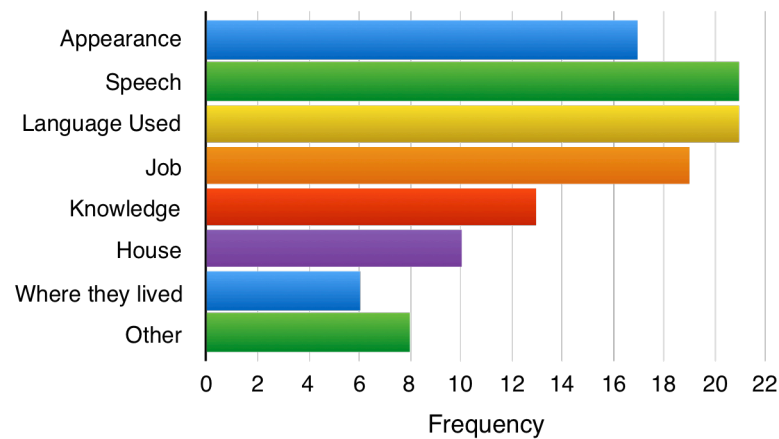


Figure 4 – Judging Therapist's Social Class

#### 4.2.2.2 Affect of social class on the therapeutic relationship

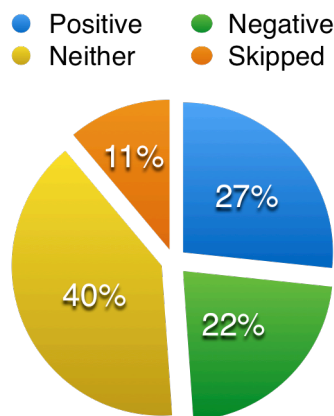


Figure 5 – Affect of Social Class in the Therapeutic Relationship

##### 4.2.2.2.1 Equality in the relationship

24 (53%) respondents felt an equality with their therapists throughout: 16 perceived social class similarity, 8 perceived social class disparity (Table 1). Of those who felt similar and were aware of the impact of social class in therapy: 10 attributed their equality to feeling intuitively understood due to social class similarity, 2 to

therapeutic attitudes and having social class acknowledged, and 1 to having a competent therapist.

Of those who perceived social class disparity and were aware of the impact of this difference: 1 attributed their equality to feeling understood, 2 to therapeutic attitudes and 1 to the therapist acknowledging their background. Despite feeling equal, the remaining 4 reported feeling judged, misunderstood, or blamed their therapist for lack of connection.

Table 1 – Enabling Equality						
What enabled equality throughout therapy? Respondents felt equal beginning/end of therapy (n=24)			What enabled respondents to feel equal at end of therapy? (n=7)			
Similar SC (n=16)		Different SC (n=8)		Similar SC (n=4)		Different SC (n=3)
Intuitively understood due to similar SC background (n=10)	UMC n=4 LMC n=2 MC n=1 UWC n=3	Felt understood (n=1)	R=LMC/ T=UWC	Therapist attitudes/felt understood due to similar SC backgrounds (n=2)	UMC n=1 UWC n=1	Challenged differences (n=1)  R=UWC/ T=LMC
Therapeutic attitudes and acknowledgment of SC (n=2)	UMC n=1 LMC n=1	Therapeutic attitudes (n=2)	R=UWC/ T=LMC n=1 R=UMC/ T=UWC n=1	Therapist attitudes & therapist self-disclosure (n=1)	MC n=1	Therapist attitudes (n=2)  R=WC/ T=MC R=UWC/ T=UMC
Competent therapist (n=1)	LMC n=1	Considered background (n=1)	R=WC/ T=MC	Self-awareness of putting therapist on pedestal (n=1)	UWC n=1	
Unaware of impact of SC in therapy (n=3)	LMC n=2 MC n=1	Unaware of impact of SC in therapy (n=1)	R=UWC/ T=LMC			
		Blamed therapist for not connecting (n=1)	R=UWC/ T=LMC			
		Felt judged & misunderstood at times (n=2)	R=LMC/ T=UMC n=2			

#### **4.2.2.2.2 Impact of hierarchy**

7 (16%) respondents felt inferior or superior at the beginning of therapy but equal to their therapist at the end (4 perceived social class similarities, 3 perceived differences) (Table 2).

14 (31%) respondents felt inferior/superior to their therapist throughout therapy (3 perceived social class similarities, 11 perceived social class differences): 9 reported some improvement in their inferiority/superiority, 3 stayed the same and 1 moved from feeling inferior to superior (Table 2).

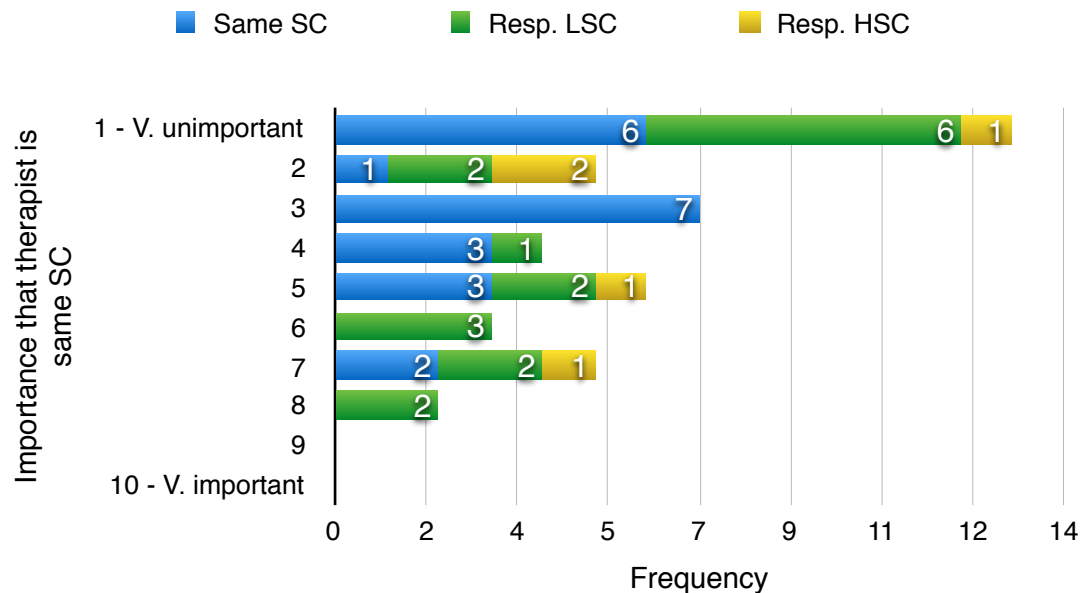
Only one respondent indicated that feelings of being more powerful than their therapist were explored and assumptions challenged. This resulted in the respondent feeling less superior at the end of therapy. The remaining 13 (unequal throughout their therapeutic relationship) made no report of differences or feelings of inferiority/superiority having been explored.

Table 2 – Impact of Hierarchy			
Reasons given for inequality			
Respondents felt either inferior or superior at the beginning and end of therapy (n=14)			
Similar SC (n=3)		Different SC (n=11)	
Reasons for inequality (number of respondents = n)	Class of therapist/respondent	Reasons for inequality (number of respondents = n)	Class of respondent (R)/class of therapist (T)
Assumptions made/felt inferior – not explored (n=1)	LMC n=1	Felt inferior – not explored (n=3)	R=LMC/ T=UMC n=1 R=LWC/ T=UWC n=1 R=UWC/ T=UMC n=1
Felt inferior – not explored /understood due to similar SC (n=1)	LMC n = 1	Felt powerful at times – was discussed. Assumptions challenged (Superiority decreased) (n=1)	R=UMC/ T=UWC n=1
Felt superior – not explored /understood due to similar SC (n=1)	LMC n = 1	Felt inferior/judged – not explored (n=1)	R=LMC/ T=UMC n=1
		Not understood – not explored (n=3)	R=MC/ T=UMC n=1 R=LMC/ T=UMC n=2
		Not understood/felt judged – not explored (n=1)	R=LMC/ T=UMC n=1
		Difference undermined relationship/not understood/felt superior – not explored (n=1)	LMC n=1
		Felt judged – not explored (n=1)	R=UMC/ T=MC n=1



#### 4.2.2.3

#### Importance of client/therapist social class similarity



**Figure 6 – Importance of Client/Therapist Social Class Similarity**

TABLE 3 – Importance of Client/Therapist Social Class Similarity							
All respondents		Lower SC than therapist		Same SC as therapist		Higher SC than therapist	
Mean ( $\mu$ )	Standard Deviation ( $\sigma$ )	Mean ( $\mu$ )	Standard Deviation ( $\sigma$ )	Mean ( $\mu$ )	Standard Deviation ( $\sigma$ )	Mean ( $\mu$ )	Standard Deviation ( $\sigma$ )
3.53	2.26	4.00	2.68	3.18	1.62	3.40	2.24

There was no significant correlation between respondents with therapist social class similarities/differences and the importance of having a therapist of the same class (Figure 6). Although 49% of all respondents reported social class as having either a positive or negative affect upon the therapeutic relationship (Figure 6), 38% of all respondents rated social class as very unimportant (1) though the ratings varied depending upon the respondent's social class, with lower-class respondents rating

client/therapist social class similarity as slightly more important (Figure 6/Table 3). The average rating (mean  $\mu$ ) for all respondents, however, was 3.53 with a standard deviation ( $\sigma$ ) of 2.26 (Table 3).

#### 4.2.2.4 Affect of social class similarity on the therapeutic relationship

Two-thirds (67%) of all respondents thought having a similar-classed therapist would improve their relationship for the reasons identified in Figures 7a and 7b.

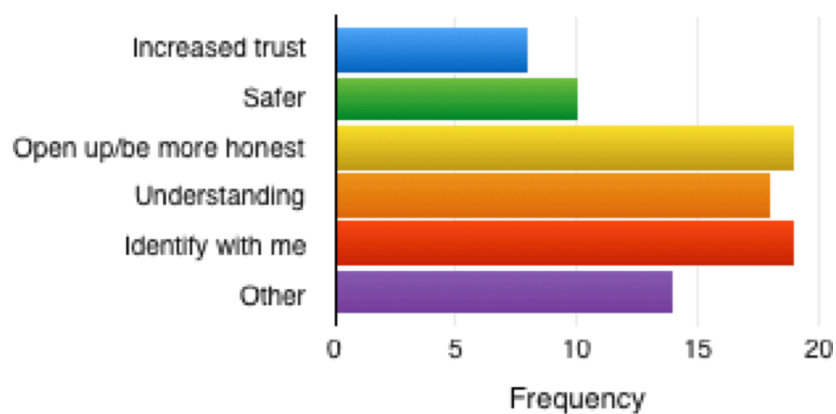


Figure 7a – Reasons why Social Class Similarity had/might have affected the Relationship

'Other' =

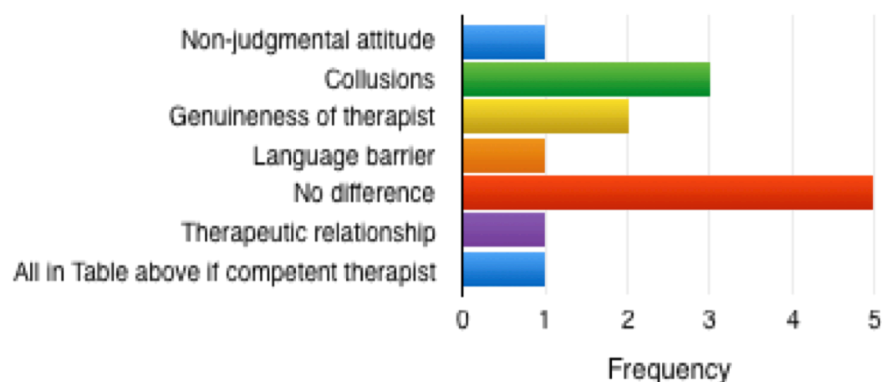


Figure 7b – Other (from Figure 7a above)

### 4.3 QUALITATIVE DATA

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During the coding process careful attention was given to categorizing, as data could be used in more than one category. The careful refinement of categories minimised this, where possible. Following analysis of the data, four primary themes emerged with ten secondary themes and eleven tertiary themes – Table 4. These were given to a fellow researcher in order to check through the reliability of the data and to validate its interpretation and collation.

Table 4 summarises the primary, secondary and tertiary themes that emerged from analysing the qualitative data.

- *Respondents are labelled R1, R2, etc.*
- *(In vivo quotes are edited for clarity – (...) represents textual omissions, text in square brackets provides contextual meaning)*

TABLE 4				
PRIMARY, SECONDARY & TERTIARY THEMES				
Primary Themes		Secondary Themes		Tertiary Themes
4.3.1	Perceptions of own social class	4.3.1.1	Defining social class	
4.3.2	Social class as a facilitative aspect of therapy	4.3.2.1	Social class discussed through therapeutic dialogue	
		4.3.2.2	Acknowledgment of social class in therapy	
		4.3.2.3	Clients' experience of social class similarity	4.3.2.3.1 Shared sense of value 4.3.2.3.2 Implicit understanding
4.3.3	Negative impact of social class on therapy	4.3.3.1	Negative impact of social class disparity	4.3.3.1.1 Fearing judgment 4.3.3.1.2 Inequality
		4.3.3.2	Negative impact of social class similarity	4.3.3.2.1 Assumptions and collusion
4.3.4	Clients' perceptions of their therapeutic relationship	4.3.4.1	Therapist attitudes	4.3.4.1.1 Helpful experiences 4.3.4.1.2 Unhelpful experiences
		4.3.4.2	Therapist interventions/ability to challenge	4.3.4.2.1 Therapist self-disclosure
		4.3.4.3	Experiencing the therapists' social class	4.3.4.3.1 Initial impressions 4.3.4.3.2 Language 4.3.4.3.3 Money
		4.3.4.4	Social class in therapy	

#### 4.3.1 Perceptions of own social class

Several respondents described very moving accounts of their experiences of class differences whilst growing up:

*Most of my classmates ... were much less able financially than my family, and I remember crying with my sister and wishing we had less money so we were more like the others, and more included (R44).*

Respondents expressing shame and embarrassment about their working class backgrounds felt inferior within their therapeutic relationships. These feelings were exacerbated when working with a therapist from a higher social group. Conversely, those respondents who felt proud of their working-class background were more likely to feel equal in the relationship, even with a higher-class therapist:

*I feel I work very hard and I am from a background of strong work ethics (R2),*

*[I] come from a strong working class background (R28).*

Several middle-class respondents described feeling guilty about their privileged positions, with one respondent stating she felt wary and scared of those different from her. Interestingly, this respondent reported feeling superior throughout therapy (though this feeling did decrease) and stated she was not as open as she could have been.

One UMC respondent (R44), who had felt guilty about her privileged status in childhood, occasionally felt more powerful than her therapist (whom she described as living '*in a working-class area*'). Her awareness of this, however, meant this was explored in therapy and resulted in R44 feeling more equal in the relationship.

#### 4.3.1.1 Defining one's social class

As predicted, this question proved contentious with many respondents: several reported difficulty in placing themselves within any of the pre-defined categories, describing themselves as 'middle-middle-', 'middle-' or 'working-' class. Some defined themselves, or felt society defined them, as 'middle-class due to their profession' despite feeling working-class:

*I feel I may be perceived to be middle class because of my education and occupation and yet I feel working class, was brought up in a working class household and am still working! (R7).*

Conversely, some still felt working-class despite their profession.

Several respondents had difficulty placing themselves above/below others:

*I feel uncomfortable defining myself and writing like this and I guess that is part of the point of the study! (R14),*

*I feel very uncomfortable even ticking that box, would normally not (R22),*

*In some way, it makes me feel uncomfortable to think of my social class because it immediately makes me put people above or below me and I don't like that (yet still do it!) (R32).*

Others felt an ability to relate across the classes due to their upbringing:

*My mother's family were[sic] lower working class and my father's upper middle. I believe I grew up "bilingual" as it were. This may have influenced ... my attitude to the class of my own counsellor" (R9).*

#### 4.3.2 Social class as a facilitative aspect of therapy

Several respondents felt that social class was an important element within their therapeutic relationship and, overall, had a significant impact on the effectiveness of therapy.

#### **4.3.2.1 Social class discussed through therapeutic dialogue**

Of 45 respondents, 9 indicated that social class was discussed in therapy:

*... I was in training and struggling with being a white middle class woman and the privilege that can come with that status (R6),*

*... discussed [social class] in terms of my marriage to an Englishman who was clearly from the upper middle class (R51).*

#### **4.3.2.2 Acknowledgment of social class in therapy**

When social class was acknowledged by therapists and explored in therapy some respondents felt equal despite social class disparity, or felt less inferior in the relationship and the complexities of social class understood:

*... she addressed the idealization. Worked through feeling inferior (R8),  
I felt my counsellor ... considered my upbringing (R7).*

Even with client/therapist social class similarities, the therapeutic relationship strengthened when social class was explicitly acknowledged:

*The fact that he ... acknowledged that even though my background was one of material privilege this did not mean that I did not also have struggles help[ed] develop the therapeutic relationship (R6).*

#### **4.3.2.3 Clients' experience of social class similarity**

16 respondents thought having the same social class to their therapist had had a positive influence on therapy. Some reported feeling more comfortable with a therapist from the same social class and, in turn, more connected:

*I think that we [were]... a similar social class and that probably helped me feel more comfortable with them. I have had experiences in the past of struggling to connect with people/therapists, often those who are seen as a higher class (R32).*

Perceiving social class similarity enabled many respondents to feel more equal and, ultimately, to being more open and honest within the relationship:

*Believing her to be in the same social class as myself allowed me to be myself and feel equal in the relationship (R40).*

#### **4.3.2.3.1 Shared sense of values**

6 respondents explained how, when perceiving social class similarity, they sensed a common background and shared values. This resulted in them feeling more inclined to trust the therapeutic space and thus, more able to open up:

*I felt she was able to understand my core values and recognize them. She was able to recognize my journey and my life experiences from a common viewpoint based in shared roots (R40),*

*I felt at ease and was able to be open and to assume a certain degree of shared values/understanding (R47).*

#### **4.3.2.3.2 Implicit understanding**

Several respondents felt perceived similarities in social class enabled them to feel intuitively understood:

*I felt the counsellor understood me well coming from a similar class background (R20),*

*I experienced the similarities in terms of feeling intuitively understood or 'got' by her. This put me at ease (R21),*

*... because I perceived her eventually as someone similar in social class there was a deeper connection and sense of understanding. I really felt she could 'get' things from my unique perspective (R36).*

Others felt a sense of solidarity:

*... what I was bringing to therapy was difficulty in a relationship with someone from a different class background to me. I felt ... the therapist understood these difficulties because she was on the same side (R21).*

There is a sense that for some working-class respondents their frame of reference could only be fully understood by a working-class therapist:

*Some life experiences of having a working class background seem to be only fully understood/appreciated by others who have that background. I think this comes from shared very ordinary daily experiences (R31).*



### **4.3.3 Negative impact of social class on therapy**

#### **4.3.3.1 Negative impact of social class disparity**

Several respondents who perceived themselves to be in a lower social class to their therapist reported holding back, putting up defences and therefore felt disconnected:

*I have struggled in the past connecting with ... therapists seen as higher social class (R32),*

*Looking back I wasn't always open with her. [I] was not able to be wholly myself (R10).*

Others felt misunderstood by their higher-class therapist:

*I felt disappointed in her lack of ability to follow me, I didn't feel understood (R33),*

*[I was] aware of difference. Felt they were more part of the establishment. Felt it might have made it harder for my therapist to understand me (R8).*

One respondent (R45) needed to be on her best behaviour when having counselling, though she did not expand on this.

##### **4.3.3.1.1 Fearing judgment**

When perceiving social class disparity several respondents found feeling ashamed of their backgrounds meant they could not be open or honest with their therapists and many withheld information or filtered their stories for fear of being judged:

*I was cautious about talking about my family of origin for fear of being judged. I had a very privileged upbringing. I was not as open as I might have been (R27),*

*The experience of poverty can create a sense of shame especially if you have children ... I would tell another working class counsellor that I smoked when I was on benefits with three kids as a lone parent ... but think that I might not share this with a middle class counsellor (R5),*

*I would have shared more about my family background had I thought my therapist was more working class (R49).*

#### **4.3.3.1.2 Inequality**

14 respondents reported feeling either inferior or superior to their therapist. Several respondents reported having their feelings of low self-esteem or inferiority exacerbated when with a higher-class therapist:

*[I] looked up to him, made presumptions that he was better than me (R5),  
I was aware that I had put her on a pedestal (R48).*

Due to feeling inferior, one respondent reported withholding information so as not to offend:

*I felt slightly inferior, and ... probably held back some of my views and actions so as not to offend. ... I think it probably hindered the effectiveness of the therapy to some extent (R45).*

Feelings of superiority led one client to ending therapy abruptly:

*I didn't stay with him for long because I had a sense that our worlds were quite different (R4 – UMC/T=LMC).*

#### **4.3.3.2 Negative impact of social class similarity**

As a vulnerable client seeking help, feelings of inferiority can be exacerbated, even when there are perceived social class similarities:

*I would have considered myself inferior simply because I am the vulnerable client seeking help (R19 – UMC).*

##### **4.3.3.2.1 Assumptions and collusion**

For some respondents, having a similar-classed therapist meant the possibility of collusion, thereby limiting their personal growth. Several respondents, perceiving social class similarities, felt there was a tendency for their therapists to assume too much:

*It made it rather too comfortable, ... I thought my therapist made assumptions about me based on perceived similar class backgrounds (R15).*

Some respondents felt their therapists imposed their own values on them:

*... I felt that at times she assumed too much and took too much for granted while I wanted to deconstruct my values and experiences which derived from my social class (R44).*

#### **4.3.4 Clients' perceptions of their therapeutic relationship**

##### **4.3.4.1 Therapist attitudes**

Therapist attitudes were important for many respondents in determining whether or not therapy was successful despite social class similarities/differences.

##### **4.3.4.1.1 Helpful experiences**

18 respondents felt their therapists' attitudes (viz.: being non-judgmental, caring, empathy, warmth [Figures 7a and 7b]) as crucial for successful therapy. 9 respondents felt that, despite perceived social class differences, positive therapist attitudes were key to them feeling accepted and understood:

*I felt aware of the difference early on but because my therapist was so warm and accepting, I never felt judged, just accepted (R2),*

*She comes as 'an ignorant' of my social class and explores with love and empathy and curiosity my perspective (R44),*

*Her acceptance and prizing of me was the greatest gift she gave me and this changed everything (R49).*

Even when initial impressions of social class difference were strong, positive therapeutic attitudes were essential for some respondents in enabling effective therapy:

*[I did] think it's ok for you, you've got a job and you're driving around in a flash car and I'm coming to you talking about not having a car to take my son*

*off to the beach or to a theme park and how sad that that makes me feel. I'm a single mum on benefits and you're a 'lah de dah' person in your flash car. These were just my impressions of her at first but because she was a genuine, real person all that disappeared and I felt accepted and that she was a real person inside (R34).*

#### **4.3.4.1.2 Unhelpful experiences**

Respondents reported difficulties in the therapeutic relationship when negative therapeutic attitudes were experienced. Difficulties were exacerbated when respondents also perceived social class differences. Some felt misunderstood:

*Sometimes she had no understanding of certain situations (R10),*

*Sometimes I felt like she was not with me, not quite getting where I was going (R33).*

Others felt therapist incongruence:

*We were completely different I could tell when he was being incongruent. It made me defended (R38).*

#### **4.3.4.2 Therapists' interventions/ability to challenge**

Having a therapist of a different social class gave some respondents the opportunity of having their prejudices and assumptions challenged and this was key to helping them grow:

*I recognized the sense of 'not being good enough' was maybe more thoroughly explored because I had this therapist [HSC] and I may not have done so with someone with whom I may have identified with more fully (R25).*

The awareness of differences in social class by the therapist as a dynamic, and then having the courage and competency to explore these differences with their client, was important for some respondents:

*Being understood was not why therapy was helpful. Being challenged in my assumptions was much better at helping me grow (R8),*

*... the therapist was exceptionally adept at respectfully challenging and not allowing an issue to be diverted. I learnt a lot from this therapy in terms of my own practice (R25),*

*I think she makes an effort to understand me [and] if she was from the same social class she would have been more able to understand me BUT I feel confident that she would not have been able to explore in such depth my experiences of being trapped in my social class (R44).*

#### **4.3.4.2.1 Therapist social class self-disclosure**

The majority of respondents received therapy in their therapists' home, where there is inadvertent therapist self-disclosure. Some respondents, repelled by initial impressions of their therapist's social class, reported feeling more intuitively understood when their therapist explicitly disclosed their social class:

*My therapist shared her working class roots with me, at a time when I needed to know she understood where I was coming from. This really helped (R49),*

*Initially ... (looking at the house and office) I would have thought she was of a lower social class but as we got to know each other I think it evened out a bit more. ... because I perceived her eventually as someone similar in social class there was a deeper connection and sense of understanding (R36).*

#### **4.3.4.3 Experiencing the therapists' social class**

Many variables associated with social class influence the effectiveness of therapy. Several respondents reported having had strong emotional reactions to these variables. However, in the majority of cases, these were not explored in therapy.

##### **4.3.4.3.1 Initial impressions**

All respondents visited their therapists' home or workplace for therapy. Many respondents judged their therapists' social class based on initial impressions of their therapists' home/workplace:

*... they seemed to own their own 'nice' home which I don't so felt different that respect and I guess envious at times (R18).*

Others felt a sense of superiority when judging their therapists' home/workplace:

*She dressed in a way that I would class as upper working class and the way her house and office looked indicated that she wasn't someone into wealth and material possessions (R36).*

Several respondents judged their therapists' social class by their appearance or the car they drove:

*She dressed in a way that I would class as upper working class (R36),*

*Attire, car, disclosures about education and where he lived (R12).*

For some, these initial impressions had a significant impact on therapy both positively:

*I think that I saw my therapist as similar class due to house, possessions, profession, personality and this helped (R32).*

And negatively:

*... he lived in a terraced house whereas I live in a detached house. So I was kind of aware that he probably in a different social class from me. I'd like to think it didn't matter – but if I'm honest, it probably did! I didn't stay with him for long because I had a sense that our worlds were quite different (R4).*

#### **4.3.4.3.2 Language**

For many respondents language, particularly articulation, was an important variable in the therapeutic relationship. Feelings of inferiority were often exacerbated. One (LMC) respondent with a higher-class therapist felt unequal throughout their relationship:

*She spoke very poshly[sic] with an upper class tone (R34).*

Others felt ashamed of their accents:

*There were moments when I wondered if he might make a judgment of me from my accent, despite the fact that I'm more qualified and experienced than him as a counsellor (R31).*

R31 described being aware of the difference in speech between her (LMC) and her therapist (UMC), both in terms of stereotypical thinking and the use of an 'elaborated code':

*He spoke differently to me, was 'well spoken'. I have a northern accent, which people often automatically assume means that I am working class. I tend to use 'plain English' whereas he used long words (R31).*

R33 was also aware of an 'elaborated code':

*Something to do with articulation of concepts – education? Use of words? (R33).*

Others felt superior due to their therapists' accent:

*She had a regional accent, which to me indicated that she was working class in origin (R51 - UMC).*

#### **4.3.4.3.3 Money**

Several respondents felt money was an important variable in the therapeutic relationship, particularly when there was perceived social class disparity:

*The amount charged. The therapist seemed one of the "twin set and pearls brigade - definitely not working class (R45),*

*I thought he was too eager to arrange the time of sessions to suit me – it suggested he needed the money! (R4),*

*In his understanding of what felt like a lot of money (R31).*

One respondent, feeling very inferior at the beginning of therapy, reported that her therapist's apparent wealth, and her having to pay for therapy despite struggling financially, impacted on their work together (though this does not appear to have been explored):

*I attend therapy at my therapist's house so I am aware of where he lives and*

*the size of his house and some of the things he owns. I think this has at times impact on the work we have done as I have felt inferior to him and angry that I have to pay him for therapy – especially when I have struggled financially (R37).*

#### **4.3.4.4 Social class in therapy**

Many respondents felt that, regardless of class, the quality of the therapeutic relationship was fundamental for effective therapy:

*It is the interpersonal relationship that is of most importance (R16),*

*to me as long as the counsellor can relate to me and enter into my reality of being then [social class is] not an issue (R22),*

*It is the therapeutic relationship which is ... core (regardless of class) (R32).*

#### **4.4 Summary**

These findings illustrate the ways in which social class can impact upon the therapeutic relationship both positively and negatively. In addition, they highlight the importance of therapists not only being aware of, but also attending to social class as a dynamic within therapy. Figure 8 clarifies the main themes arising from this study.



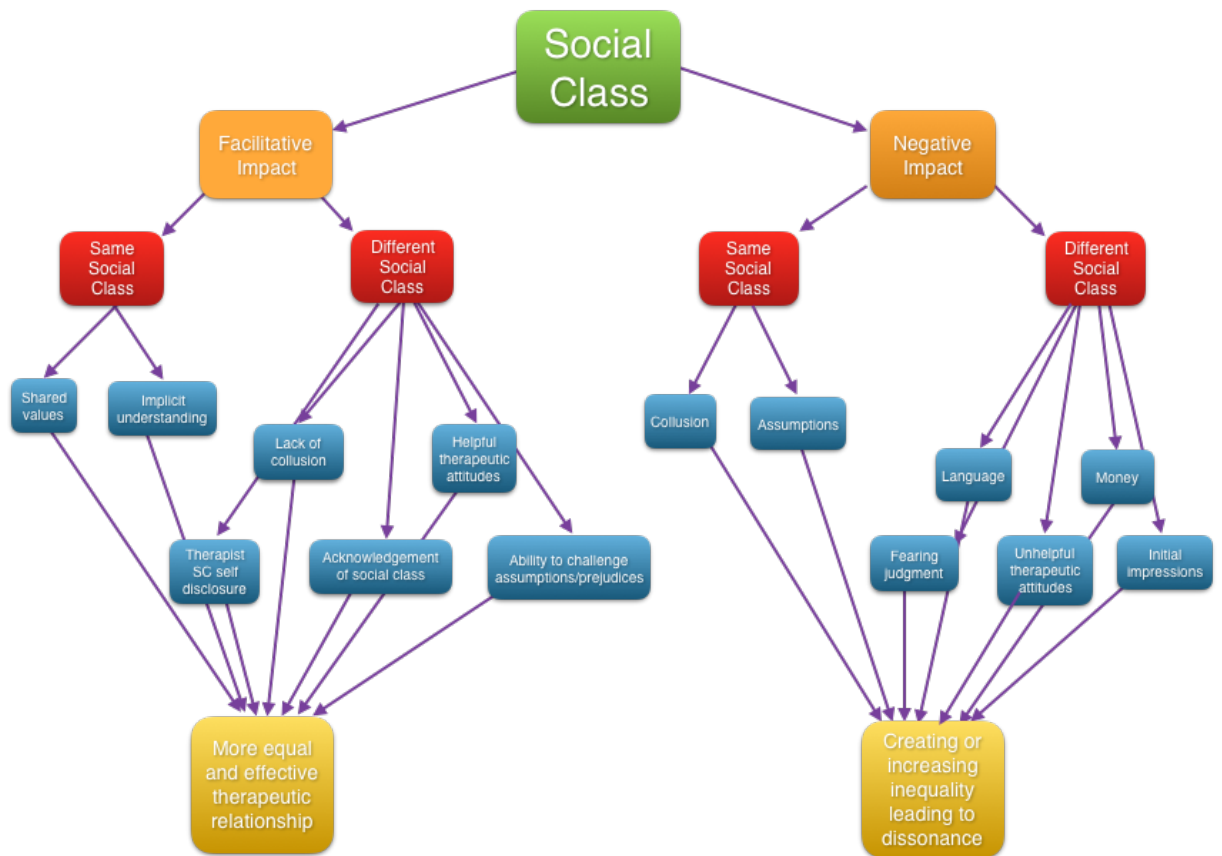


Figure 8

### IMPACT OF SOCIAL CLASS ON THE THERAPEUTIC RELATIONSHIP

## 5. DISCUSSION

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*'Any city, however small, is in fact divided into two, one the city of the poor, the other of the rich; these are at war with one another.'*

Plato - Greek philosopher (427-347 B.C.)

### 5.1 Introduction

Using a questionnaire survey, this study explored the extent to which perceived social class disparity between client and therapist impacted on the therapeutic relationship. Results demonstrate the multidimensional complexities of social class, consistent with the literature (Liu, 2011; Sayer, 2005).

Literature on social class in therapy commonly explores two categories: middle-class therapist/working-class client (predominantly), and working-class therapist/middle-class client (Balmforth, 2009; Isaac, 2012; Ryan, 2006; Thompson, et al., 2012). However, findings from this study also show factors affecting client/therapist social class similarity.

Overall, there was a sense that social class (whether of client/therapist similarity or disparity) had a far greater impact on respondents than they initially thought, with some respondents not recognising the impact until taking part in this study:

*[Social class] slightly undermined the relationship ... Not in a really overt way, but in subtle ways that are clearer in retrospect than at the time (R4).*

This is consistent with Savage, Bagnall and Longhurst (2001) and Skeggs (2004), who state how few people admit to the impact of social class on their lives and relationships. However, despite many respondents' accounts of social class being, generally, an irrelevant dynamic, social class was shown to be "a potent cultural

force” (Piff et al., 2012, p.960) in the therapeutic relationship, whether consciously or unconsciously (Walkerdine, 2007), with differences and similarities both helping and hindering the relationship in a number of ways.

## **5.2 Defining Social Class/Class Identity**

In accordance with Bottero (2004), many respondents had difficulty defining their class position, with reluctance and uneasiness for some in placing themselves above or below others. Though several respondents recognised the subjectivity and complexity of defining social class, particularly where there were other socio-demographic factors such as culture and race (Liu, et al., 2004), most respondents used objective socioeconomic indices (ONS, 2015) as determinants of their social class.

There was discrepancy between some respondents who identified themselves as having working-class roots; some defined themselves (or felt society defined them) as middle-class due to their profession, something Totton (2009) and Rothblum (1996) claim is inherent in the role; whereas others, regardless of these factors, still felt working-class and had a sense of pride in being such. Rothblum (1996), however, argues that it is impossible to be a therapist and still be working-class, something often ignored by those with working-class backgrounds. Some middle-class respondents felt their working-class backgrounds provided them with an holistic understanding of social class at both levels regardless of their therapist. Mitchell and Namenek’s argue that therapists “from lower ... class backgrounds [may retain] sufficient class-determined characteristics and behaviours to meet the expectations of lower-class clients” (Mitchell & Namenek, 1970, p.225). However, this may also be

apposite for *clients* with lower-class roots meeting the perceived expectations of their lower-class therapists.

### **5.3 Social Class as a Facilitative Aspect of Therapy**

A quarter of respondents felt social class had played a facilitative role within their therapy; with most of those experiencing disparity believing social class similarity would have had a positive impact on their therapeutic relationship for the reasons given below (see also Figures 7a and 7b).

Despite a plethora of quantitative studies on the impact of perceived social class similarity on the therapeutic relationship (as reported in the literature review), there is a dearth of qualitative material. Findings from this study demonstrate however, how, for many respondents, perceiving social class similarity meant having a sense of sharing similar core values and of feeling intuitively understood (Hoyer & MacInnes, 2009; Maluccio, 1979). Being understood at this innate level enabled them, as clients, to feel not only equal and comfortable in the relationship, but also deeply connected to their therapist: they trusted the relationship completely without fear of judgment, and were thus more open and honest, thereby creating a strong, effective working alliance. This supports work by Alexander and Luborsky (1986) who claim that for a positive working relationship clients must believe they share a common conceptual viewpoint. However, a few respondents, with a strong self-concept, thought client/therapist social class similarity was irrelevant.

Where there was social class disparity, several respondents believed the therapeutic alliance was strengthened when their therapist explicitly acknowledged social class as a variable in therapy, as highlighted in several studies (Balmforth,

2009; Ryan, 2006; Thompson, et al., 2012). Explicit acknowledgement of social class disparity enabled clients to feel that their therapists recognised and respected the complexities relating to their social class (Thompson, et al., 2012). Though two respondents reported possibly having a deeper connection had they had similar-classed therapists, both state their inequalities were more thoroughly explored by someone ignorant of their social status. When therapists, with limited knowledge of their client's different social class, explore with love, empathy and curiosity, this:

- avoids the possibility of collusion (discussed in 5.4)
- helps dissolve power imbalances, thereby creating equality in the relationship
- enabled one respondent to explore and work through feelings of inferiority.

Moreover, even when there was client/therapist social class similarity, explicit acknowledgment of social class by the therapist led to increased authenticity and a more effective relationship in which both therapist and client developed (Kim & Cardemil, 2012).

For social class to be acknowledged however, therapists need to be aware, not only of their “own class position and values, and [be] comfortable with them” (Chalifoux, 1996, p.33), but also the importance of social class as a variable in therapy, how it can affect people's lives, together with having some knowledge of how different classes respond differently in times of stress (Piff, et al. (2012): these are particularly pertinent when there is social class disparity.

#### 5.4 Negative Impact of Social Class on Therapy

Regardless of client/therapist social class similarity/disparity, a quarter of respondents reported social class as having a negative impact on their relationship. Despite many respondents reporting how social class did not affect their therapeutic alliance, several of these had strong reactions to initial impressions and of feeling unequal, attributions that are “often emphasised within the intensity of the therapeutic encounter” (Ryan, 2006, p.60). The lack of awareness reflects, perhaps, how social class impacts on the relationship in other, more elusive ways (Kraus, et al., 2012).

Where there was social class disparity (irrespective of social status), feelings of inequality were often accompanied by shame or guilt over their background (Proctor, 2006). Some respondents said they were scared of those who were different; issues that resonate with work by Ryde (2009) on race and culture in therapy. Others felt misunderstood or fearful of being judged, creating or increasing feelings of inequality, and felt their frame of reference could only be fully understood by a similar-classed therapist:

*I would tell another working-class counsellor that I smoked when I was on benefits with three kids as a lone parent ...but ... not ... with a middle-class counsellor (R5).*

This echoes Balmforth’s study (2009) in which clients felt their therapist was unable to enter their frame of reference. There is also a sense lower-class clients felt oppressed and/or unable to match higher-class ideals (Chalifoux, 1996), with many respondents reporting how having a higher-classed therapist influenced their behaviour (Sennett, 2003):

- feeling inadequate and fearing judgment, several clients withheld information,

filtered their stories or became defensive, possibly, as Chalifoux (1996) remarks, in an attempt to redress the power imbalance,

- fearing judgment, R45 felt she needed to be on her 'best behaviour', resonating with a study by Romero-Canyas and colleagues (2010) which found that individuals often engaged in 'ingratiating behaviours' in an attempt to thwart rejection.

Where feelings of inferiority existed throughout therapy, comments of their therapist being "*part of the establishment*", "*very well educated and had written papers*", suggest that respondents had put value on education/knowledge (Seabrook, 2002) and felt inadequate due to their therapist's superiority of rank. This resonates with Bourdieu (2010), Lott (2012), Sennett and Cobb (1972), and Totton (2009) who all state how those in authority deal out the symbols of power to those in its ranks, thereby increasing the power of the therapist and exacerbating the client's powerlessness. Conversely, power gained from material wealth and knowledge (and therefore their therapists' lack of it) (Seabrook, 2002), and/or high JWBs: "*I grew up abroad in an ex-pat community. We definitely felt 'superior' to the natives*", and "*I was raised to think we were better than others*", fuelled respondents' feelings of superiority that existed throughout therapy.

It appears that all the aspects of power, defined by Proctor (2006), viz.: societal, role and historical, were being re-enacted within many therapeutic relationships, leading to defensive attitudes, mistrust and disconnection. If these are not addressed within therapy, Chalifoux (1996) warns that shame, secrecy and guilt are perpetuated reinforcing the inferior client's feelings of powerlessness and subordination (Goodwin, Kaestel & Piercy, 2013), or keeping the superior client stuck in a cycle of

collusion and oppression (Baughan, 2014; Utt, 2014).

Interestingly, findings from this study show inequality also exists where there is social class similarity, something Liu (2011) terms '*lateral classism*'. However, feelings of inferiority were generally exacerbated in lower-class clients with a higher-class therapist, supported in research by Balmforth (2009) and Proctor (2002). Furthermore, feeling inferior (and in one case, superior) to the therapist was most often felt in respondents who already felt vulnerable, had low self-esteem, or there was earlier experience of classism. These power imbalances, often originating from innate socialisation messages garnered since birth (Kim & Cardemil, 2012) and from classism experienced earlier in life (Liu, et al., 2007; Ryan, 2006), were being felt within the hierarchical structure of the therapeutic relationship (Chalifoux, 1996). When 'One' meets the 'Other' within the intensity of this encounter, tensions arise, feelings of inequality are exacerbated, and old power struggles are re-enacted (Bourdieu, 1990; Proctor, 2006).

When there is *shared* social class, therapists need to be aware of their own frame of reference (Pope & Arthur, 2009) as, interestingly, a few respondents in this study showed there was a tendency for their similar-classed therapists to assume too much, or to impose their own values on their clients: that their way of seeing social class was ubiquitous (Liu, 2011). Moreover, respondents who felt inferior appeared unable to raise this issue with their therapists, perpetuating feelings of powerlessness and inequality: findings which are supported in work by Balmforth (2009), Harrison (2013) and Proctor (2006).



Some respondents believed that having a similar-classed therapist meant there was the possibility of collusion: where therapists

blind to important areas of exploration, emit subtle cues which allow clients to avoid exploration of significant material, [resulting] in interventions that do not serve the best interests of the client (Fox & Carey, 1999, p.197).

When assumptions were challenged and explored, one respondent reported having experienced more personal growth and that their feelings of inequality diminished.

Only one client (R4, who felt superior to their therapist) reported social class disparity as a reason for terminating therapy prematurely. Generally, there was no correlation between social class similarity/disparity or of feeling equal/unequal and length of time in therapy, contradicting research by Hollingshead and Redlich (1958), and Rokeach (1960). Nor was there any indication that having a higher-classed therapist created dependency, again contradicting research by Pettit, et al. (1974). However, these discrepancies may be due to my research being limited to clients who are themselves therapists, rather than with 'real' clients, as was the case in the aforementioned studies, or the limited nature of the questionnaires themselves.

## **5.5 Relationship Quality**

Respondents generally felt that the therapeutic attitudes of empathy, warmth, caring and being non-judgmental were key in enabling them to feel safe, equal and accepted, regardless of social class disparity/similarity, and this is consistent with the literature (Howe, 1993; Knox, 2008; Ladany & Krikorian, 2013; Sands, 2000; Thompson, et al., 2012). When respondents reported having strong initial impressions/assumptions of social class disparity, these positive therapeutic attitudes were especially important in creating a strong, effective and trusting

alliance, within which clients could open up and be honest without fear of judgment (Ladany & Krikorian, 2013). Wolken and colleagues (1973) emphasise the importance of exploiting these conditions, especially empathy, to improve the effectiveness of therapy when there are cultural differences, and this also applies to class differences, since many respondents highlighted an empathic understanding as crucial for successful therapy.

However, these therapeutic attitudes alone did not always beget equal relationships, a point echoed by Chalifoux (1996), where for some respondents, feelings of inequality, although decreasing marginally, still existed at the end of therapy and this was the case regardless of social class similarity/disparity. More significant however, was the skill of the therapist to challenge assumptions and/or prejudices. These assumptions appeared to be better challenged by a different classed therapist, since some respondents felt their depth of exploration was only achievable due to a therapist from a different social status.

## **5.6 Experiencing the Therapist's Social Class**

Although Liu (2011) claims that social class is virtually invisible, most respondents had a strong sense of their therapist's social class, since all visited their therapist's home or workplace for therapy, and based their judgment on their therapist's home/neighbourhood. Howe (1993) highlights how a client's initial impressions have a critical impact on his/her willingness to proceed in therapy; when respondents perceived apparent wealth, societal power relationships, as defined by Proctor (2006), were often reenacted between client and therapist triggering feelings of envy, anger and shame, and exacerbating feelings of inferiority:

*I attend therapy at my therapist's house so I am aware of ... the size of his*

*house and some of the things he owns. I think this has at times impacted on the work we have done as I have felt inferior to him and angry that I have to pay him for therapy (R37).*

Therapists' homes were thus often viewed as symbolic representations of power and rank: a "badge of ability" (Sennett & Cobb, 1972, p.64). Balmforth (2009) stresses how these attitudes can be deeply ingrained and there is a danger that when societal power, the role power inherent as a therapist, and possible historical powerlessness of the client are combined, the effectiveness of therapy can be seriously undermined (Proctor, 2006).

Conversely, feelings of superiority (possibly triggering JWBs – '*the poor are less worthy*' [Smith, et al., 2011]) were felt in one respondent when perceiving their therapist's lack of wealth, undermining the relationship. There was recognition that if there had been client/therapist social class similarity, then the client would feel understood:

*He lived in a terraced house whereas I live in a detached house. So I was kind of aware that he was probably in a different social class from me... I didn't stay with him for long because I had a sense that our worlds were quite different (R4).*

Again, there is the sense that these differences and strong emotions were not acknowledged in therapy, and that it was the therapist's job, and not the client's, to address these. Balmforth (2009, p.382) emphasises how important it is to the success of therapy that therapists are "aware of and acknowledge these [attitudes] as a dynamic".

However, for several clients, initial impressions/assumptions of their therapist's social status meant perceiving class similarity: thereby having shared values and a

common background, sensing they would be understood and not judged, and feeling equal within the relationship (Howe, 1993).

Language and, in particular, articulation were also important inter- and intra-variables within the relationship, intensifying feelings of inequality, particularly when there was social class disparity. Several lower-class respondents described their therapists as having an ‘upper-class tone’, ‘well-spoken’ or ‘using long words’: the ‘elaborated code’ as defined by Bernstein (1977), thereby emphasising structural inequalities. There was a sense of anger in one respondent (R34) who, although indicating that her relationship was not affected by social class, viewed her therapist as “*lah de dah*” due to her “*posh voice*” and “*flash car*”, and believed her therapist would be unable to understand her struggle as a single mother on benefits.

Another respondent viewed her northern accent as inferior to that of her higher-classed therapist and feared being judged because of it. An upper-middle-class respondent thought her therapist was working-class due to her ‘regional accent’. These accounts are consistent with the literature illustrating how middle-class oration can be seen as superior (Bernstein, 1977; Kearney, 2010), triggering stereotypical assumptions/JWBs (Holman, 2014); in other words, classism. Though R34’s feelings of inferiority decreased marginally, she still felt inferior at the end of therapy and these feelings do not appear to have been explored.

Despite much being written in the literature on the importance of dress in the therapeutic relationship (Isaac, 2012; Liu, 2011; Scholar, 2013; Skeggs, 2011; Smith, 2010) and many respondents indicating in the ‘tick boxes’ that dress and appearance were important identifiers in judging their therapists’ social class, only

one respondent (R36) gave an account of how dress influenced their initial impressions of their therapist, heightening her feelings of superiority.

Furthermore, only one respondent (R48) gave an account on the impact of appearance. Struggling with low self-esteem and little confidence, R48 reported having had difficulty with her higher-classed therapist whom she described as “*stiff*” and “*controlled*” throughout her 18 months in therapy. Again, this does not appear to have been challenged by the client (possibly due to her lack of confidence) or recognised by her therapist.

When initially repelled by first impressions of their therapist’s social class, several respondents felt a balancing of power in their relationship and a deeper connection when their therapists explicitly disclosed their own social class, supporting work by Harrison (2013). Therapist’s social class self-disclosure, particularly when there were working-class roots, had the effect of loosening the shackles of middle-class power and dominance (Harrison, 2013) and enabled working-class clients to feel more intuitively understood. Feelings of superiority diminished for one respondent following their therapist’s social class disclosure as they began to see their therapist as a person and not just as a therapist (Knox, 2008).

Money was a factor not previously considered since it had not surfaced in the literature search in connection with social class, though its impact on therapy in general is the subject of much debate (Barth, 2001; Doherty, 2012; Field & Hemmings, 2007; Tudor, 1998). Several respondents felt money was an important variable in their therapeutic relationship when there was perceived social class disparity: intensifying feelings of inequality and reenacting power struggles between

those who could and could not afford therapy (Barth, 2001; Christens, et al., 2012); thus supporting Piff and colleagues (2012) who state that social class shapes individuals' perceptions, interpretations and how they respond to threat.

## **5.7 Summary**

Although there were many accounts of initial assumptions/impressions and oration having a profound impact on respondents' feelings of inequality within the encounter, for the majority of respondents, regardless of their social status, social class was considered largely an extraneous factor within their relationship. Most felt the quality of the therapeutic relationship was key to them feeling understood.

Generally, client/therapist social class similarity meant client equality and a greater rapport. However, social class disparity, classism (upward, downward and lateral [Liu, 2011]), and a lack of recognition of social class as an elusive but powerful force within the therapeutic relationship, reinforced clients' feelings of inequality and power/powerlessness.

## **5.8 Limitations**

Whilst I carefully bracketed my own biases, values and experiences of social class, as a novice researcher there was a danger of these emerging during the analytical process. This was mitigated through the careful use of supervision.

Other limitations included:

- Excluding other socio-demographic factors, *inter alia*: race, culture, may have influenced the findings.
- Due to ethical considerations, this study only employed trainees and/or

practicing therapists who are likely to be more self-reflective than the population as a whole. Therefore, extrapolation of this data to 'real' clients, whose perceptions of social class in therapy may be very different, should be avoided.

- The majority of respondents were female and middle-class (which is representative of the therapeutic profession as whole [Proctor, 2011]). Having a relatively homogenous group, therefore, may bias the results (Audiencedialogue.net, 2014).
- Though adverts specifically asked for those who were aware of the impact of social class disparity in therapy, in reality some respondents were not particularly aware of this. However, their answers were included in order to provide a more rounded and less biased exploration of the research question.
- Limitations of questionnaires: predetermined categories could have influenced respondents' thoughts when it came to answering open-ended questions.
- The questions could have shaped the responses in such a way they follow a path pre-determined by the researcher (Denscombe, 2010).
- Not all respondents' questionnaires were completed as fully as would have been preferred for the qualitative element of the study.
- There is the possibility that answers may not be as accurate as they could be (Denscombe, 2010; McLeod, 1994).
- In order to comply with word count limitations, some data has been excluded which may, or may not, have a bearing on the findings.

## **5.9 Implications for Therapists**

Despite much being written in the literature regarding social class and its implications on the therapeutic relationship, the impact of social class and classism still go largely unrecognised. Consciously, though predominantly unconsciously, classism appears to be prevalent within the therapeutic encounter irrespective of social status. Therapists' lack of awareness of social class as an elusive, but powerful force within the therapeutic relationship has been shown to lead to inadvertent oppressive and/or classist behaviour.

Though client/therapist social class matching generally appears to produce comfortable, equal and effective relationships, supporting the similarity-attraction theory (Berscheid & Hatfield, 1969; Byrne, 1971; Byrne, Clore & Smeaton, 1986; Yeong Tan & Singh, 1995), there is the danger that therapists may, unintentionally, assume too much and use their own frame of reference as reality and/or collude with their clients. This could result in oppressive relationships inhibiting client's psychological growth.

Social class disparity may be especially pronounced within the NHS and charitable organisations, where clients are often from the lower-classes and are already disadvantaged, with many feeling inferior and powerless. Therapists, therefore, need to be especially aware of how they themselves (*viz.*: appearance, manner, language, expectations, values) can impact profoundly on their clients, and take steps to mitigate this imbalance by, not only exploiting the positive therapeutic attitudes, but also by adapting their behaviour or language and, perhaps more importantly, by employing their skills to explicitly acknowledge and explore the disparity within therapy if appropriate. Moreover, it is also imperative that therapists



are aware of how these constructs can engender strong reactions within their clients affecting, not only their behaviour, but the quality and effectiveness of therapy, and this is especially paramount when therapists work from home.

As mentioned in previous studies on social class, it is imperative that therapists, supervisors and trainers examine and become aware of their own class backgrounds and how this affects their own frames of reference, and engage in continual reflective practice and make full use of supervision.

### **5.10 Reflections**

I began this Master's dissertation feeling enraged at the way the impact of social class appeared to go unrecognised, particularly amongst the privileged. Working within the health service in a deprived part of the country, I am constantly reminded of social inequalities and the impact this has on health and well-being. Furthermore, other health professionals appear quick to dismiss poorer clients, with their chaotic lifestyles and their irregular attendance, as not being psychologically-minded and/or failing to engage in therapy. Since health professionals are, by default, middle-class, in undertaking this study I have found that many are unaware, not only of their social status or of classism, but of the impact these factors have on the relationship.

Since undertaking the literature review I have felt overwhelmed by the sheer complexity and 'multidimensionality' of social class: every aspect of social class was inextricably linked so that it became incredibly difficult to disentangle one bit from another. This, together with the number of relevant completed questionnaires, has meant an abundance of data.

Although I had a heightened awareness of social class and believed I was aware of classism and took steps to avoid this, in conducting this study I have recognised how classist I have been, and how classism (upward, downward and lateral) is so pervasive, not only in therapy, but in life generally. I have been moved to tears when reading some middle-class respondents' accounts of the traumatic impact privilege had had on their lives: this has given me a completely new perspective and I shall be eternally grateful to those respondents for that. I hope the findings from this study enable other therapists to approach the subject of social class and classism in the therapeutic relationship in a different light: that I enable the '*class-blind*' to see.

## 6. CONCLUSION

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*'A State divided into a small number of rich and a large number of poor will always develop a government manipulated by the rich to protect the amenities represented by their property.'*

Harold Laski (British political theorist) (1893-1950)

The aim of this research was to explore, using a questionnaire survey, clients' perceptions of social class and whether, and if so how, perceived social class disparities between client and therapist impacted the therapeutic relationship.

Though initially the intention of this study was to explore the impact of social class disparity on the therapeutic relationship, such was the response that it was expanded to also include the impact of social class similarity, since these responses allowed for a full exploration of the subject. Furthermore, not only was the response rate overwhelming, but also the entire subject of social class proved immense, both in its complexity and its 'multidimensionality'.

Social class disparity and similarity were found to both help and hinder the therapeutic encounter irrespective of social status of client and therapist, although matching client/therapist social class appeared to create more effective relationships with greater client/therapist equality and rapport.

Interestingly, despite many respondents experiencing strong reactions to initial impressions/assumptions of their therapists' social status, with many feeling unequal, at least at some point, within their relationship (with several respondents feeling unequal throughout), social class was generally viewed as being an extraneous factor within the therapeutic encounter. This shows, perhaps,

respondents' lack of awareness of the more subtle ways that social class and classism can affect one's perceptions and experiences.

It would appear, despite several fairly recent studies exploring the impact of social class and classism within the helping professions, that these two factors still remain essentially inconsequential within the therapeutic community. Whereas race/racism and gender/sexism receive much attention, not just within research but also within the media, issues related to class/classism receive very little: possibly, since it has been part of the fabric of our society for centuries, that it has now become innate within British culture. However, the impact of social class/classism on an individual can be immense, regardless of their social status, and yet this impact is often ignored and deemed insignificant.

Consciously or unconsciously social class and classism are powerful forces in the therapy room enabling or disabling the relationship regardless of social class similarity or disparity of client/therapist. When these forces go unrecognised and unacknowledged therapeutic progress can stall. For a client to take full benefit from therapy therapists *must* be aware of how social class and classism can impact the relationship and be prepared to explicitly acknowledge, and challenge, these dynamics when appropriate.

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## 8. APPENDICES

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### APPENDIX A

#### List of Key Words and Search Engines Used

##### Search Engines

- PsycINFO, PsycARTICLES, PsycBOOKS, Psychology, Behavioural Sciences and Sciencedirect.com
- SocINDEX
- The University of Chester Library
- Google Scholar/Internet
- Taylor and Francis Online, Wiley Online Library, Cambridge Journals Online
- Web of Science
- Therapy Today Online
- Various personal and borrowed text books and journals

##### Search terms (using various computations of the key words):

Counselling, psycho-therapy/ology, relationship/alliance, therapy

Social class/status, socio-economic

Perspectives, assumptions, attitudes, initial impressions

Similarity, disparity, difference

Dress, appearance, language

Inequality, power, privilege, prestige

United Kingdom, Britain, England, Wales

## APPENDIX B

### Research Study Advertising Poster

To what extent do perceived differences in social-class between client and counsellor impact upon the therapeutic relationship?



The client's perspective.

Are you a trainee counsellor or newly qualified counsellor and have recently had your own personal therapy?

Has social-class been an issue for you when having your own personal therapy?



Would you be interested in filling in a questionnaire about your experiences?

If so, please contact the researcher, Alison Trott, for further information at:

(phone number and email address)

This research project will form part of my MA in Counselling Studies at the University of Chester.

## APPENDIX C

### Research Study – Inclusion and Exclusion Criteria

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#### INCLUSION CRITERIA

**Counselling trainees (on at least a Level 4 diploma course or its equivalent and on a supervised placement), qualified counsellors, psychotherapists or psychologists in supervised practice**

A prerequisite of the study that all respondents must be in supervised practice to ensure a) that only counsellors/psychotherapists/psychologists completed the questionnaire, b) minimum standards of practice.

**All respondents must have had personal therapy but must not be in therapy at the time of participating**

A prerequisite that respondents had had their own personal therapy in order that they could answer the questions fully. It was important that they were not having therapy at the time of completing the questionnaire due to the impact answering the questionnaire might have had on their therapeutic relationship.

**The research is to be taken from them in their role as client**

This was crucial as the study was from the client's perspective and not the therapist's.

**Counsellors, psychotherapists, psychologists or counselling trainees who have perceived a difference in social class between themselves and their counsellor regardless of whether or not this has impacted upon the therapeutic relationship**

It was important that respondents had been aware of differences between themselves and their therapist in order to be able to answer the questions as fully as possible.

**Counsellors, psychotherapists, psychologists and trainees must have access to personal therapy should something arise from the study that causes them distress**

Should completing the questionnaire distress the respondents, it was important that they had access to support to help them resolve any issues and to minimise risk.

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#### EXCLUSION CRITERIA

**Counsellors, psychotherapists, psychologists or trainees who are currently undergoing personal therapy**

A prerequisite that respondents were not having therapy at the time of completing the questionnaire due to the impact answering the questionnaire might have on their therapeutic relationship.

**Counsellors, psychotherapists, psychologists or counselling trainees who are not in supervised practice/on a supervised placement.**

A prerequisite of the study that all respondents must be in supervised practice/placement to ensure minimum standards of practice.

## **APPENDIX D**

### **Advertisement – TherapyToday.net Noticeboard – May & September 2015**

SOCIAL CLASS - Seeking trainee/qualified counsellors/psychotherapists (not currently in therapy) to fill in a questionnaire (via Survey Monkey) - this should take about 30 minutes. I am researching the extent to which perceived differences in social class between client and counsellor impact upon the therapeutic relationship from the perspective of the client as part of my MA at the University of Chester. If you are interested, please use this link to access the participant information leaflet and questionnaire: (email)

### **Email sent to Academic Institutions requesting permission to advertise**

Dear Sir/Madam

I am undertaking some research, as part of my MA at University of Chester, into the impact of social class on the therapeutic relationship (supervisor Dr Andrew Reeves). Data will be collected via questionnaires and I was wondering if you would be willing to place posters advertising for participants in suitable locations at your venues?

If you are able to help me with this, I shall email you the poster. If you would like further information from me regarding my study, please feel free to email me.

Kind regards.

Alison Trott

## APPENDIX E

### Feedback from Pilot Questionnaires

My overall comment was it was a little difficult to do 'online' with the boxes set up as they were (but you will see those!!).

Also, I wasn't sure what to put for question 10 as I felt the previous question had really covered the points - so not sure what else you were looking for?

It took me about 30 -40 minutes to do with comment - BUT I guess I didn't have any real issues so it may take others longer / may have more to say, if different social class to their counsellor?

It depends what your expectations are from this study. One bit I did find a little difficult was thinking about if I had had a counsellor of a differing social class - this was then more a 'guess' of how I might feel rather than reality.

It was interesting that the question 9 suite of questions about inferior - superior though took me in a direction more about experience of the counsellor than social class - what I wasn't sure about though was - did you mean it to be about anything, rather than around social class?

I noticed something important about the questionnaire - most people will want to download it and complete it electronically rather than handwriting it. However, I notice that the boxes for completing are not text boxes or tables and therefore don't allow you to complete it by typing into the boxes. So think it would be a good idea to amend the questionnaire so that it can be completed electronically - even the little boxes to tick your age etc. need to be text boxes so that people can insert a tick. Does this make sense? Please feel free to ring me if you want.

## APPENDIX F

### Research Study Covering Letter

UNIVERSITY OF CHESTER  
DEPARTMENT OF SOCIAL STUDIES AND COUNSELLING  
MASTER'S DEGREE IN COUNSELLING STUDIES

#### **SOCIAL CLASS AND THE COUNSELLING RELATIONSHIP: THE CLIENT'S PERSPECTIVE:**

**To what extent do perceived differences in social-class between client and counsellor impact upon the therapeutic relationship?**

Thank you for requesting information about my research study.

Before you decide whether or not you wish to participate, it is important for you to understand why the research is being done and what it will involve. In addition, having your informed consent is a condition of taking part. Returning to me the completed questionnaire will indicate that you have read and understood the enclosed information leaflet, have had the opportunity to ask questions if you need anything clarifying, and know that you have the right to withdraw from the study at any time. Should you wish to withdraw, you will need to quote your unique number in the top-right corner of the information leaflet.

#### **Who am I?**

My name is Alison Trott. I am a qualified counsellor and am currently undertaking a Masters Degree. This research project forms part of the Masters in Counselling Studies degree at the University of Chester. This research is being supervised by Dr Andrew Reeves (email) who can be contacted should you have any complaints.

#### **What is the purpose of the study?**

The aim of this study is to explore how you perceived any differences in social-class between yourself, as the client, and your counsellor, and in what ways, if any, these perceptions impacted upon the counselling relationship.

It is hoped that this study will give you, the participant, an opportunity to have your views and experiences considered.

It should take no more than about 40-45 minutes or so of your time to complete the questionnaire.

**If you are interested in taking part in this study, it is very important that you read the enclosed information leaflet so that you are fully informed about issues such as data protection, confidentiality, risks, benefits, etc., before completing and returning the questionnaire. If you have any questions or need anything clarifying please do not hesitate to contact me before returning the questionnaire.**

Thank you for your time in reading this.

**Alison Trott**

## APPENDIX G

### Research Study Information Leaflet

UNIVERSITY OF CHESTER  
DEPARTMENT OF SOCIAL STUDIES AND COUNSELLING  
M.A. IN COUNSELLING STUDIES

### INFORMATION LEAFLET

#### **SOCIAL CLASS AND THE COUNSELLING RELATIONSHIP: THE CLIENT'S PERSPECTIVE.**

#### **To what extent do perceived differences in social class between client and counsellor impact upon the therapeutic relationship?**

Before you decide whether you wish to take part, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If there is anything that is unclear or you would like some more information, please do not hesitate to contact me on: (email and phone number).

Thank you for reading this.

#### **Who am I?**

My name is Alison Trott. I am a qualified counsellor and currently undertaking an M.A. in Counselling Studies at the University of Chester.

#### **What is the purpose of the study?**

We are often told that we live in a class-less society. But is this the case? Does social class affect the counselling relationship?

The aim of this study is to explore *your* perceptions of differences in social class between you (as the client) and your counsellor, and in what ways, if any, these perceptions impacted upon the counselling relationship.

There has been a lot of research looking at race and culture, sexuality and gender, faith and age, and how these factors impact on the counselling relationship. Very little research has been done on social class or taken clients' perceptions into account.

Your experiences and perceptions of how you think social class might have/or might not have impacted on the personal therapy you have had are important. I hope that this study will give you, the participant, an opportunity to have your views and experiences considered.

Your answers are vital in helping counsellors understand whether social class is an issue, and if so, how best to address social class within the counselling relationship. Your contribution could make a difference to the way in which counselling is conducted in the future.

*Your answers to the questionnaire should be based on your experiences/perceptions of how social class may have impacted on the counselling relationship when you were having your own personal therapy.*



### **Who are the participants?**

Trainee and qualified practising counsellors, psychotherapists and psychologists who have undergone their own personal therapy within the past 5 years and have regular, ongoing supervision, are being invited to take part. It is a requirement of the study that participants must NOT currently be having personal therapy.

### **Do I have to take part and what procedures are involved if I do take part?**

It is entirely up to you whether or not you decide to take part. If you do decide to take part it is important that you keep this information leaflet and complete the questionnaire as fully as you can via the link:

(link)

It is a requirement of the University of Chester that I obtain participants' informed consent. Completing and submitting the questionnaire will indicate that you have read and fully understood the information provided in this leaflet, that you are aware of the implications of taking part, that you have had the opportunity to ask questions should you need anything clarifying, and that you are aware that your participation in this study is entirely voluntary.

### **Your right to withdraw**

There is no right to withdraw, as once submitted through Survey Monkey, it is not possible to retrieve individual and anonymous questionnaires.

### **What are the possible disadvantages and risks of taking part?**

It could be that some unexplored feelings about your previous counselling relationship could arise when completing the questionnaire. Should you feel any emotional discomfort or distress due to issues that arise when completing the questionnaire, professional support is strongly recommended. Contact information is provided at the end of this leaflet to enable you to get support should you need it. Alternatively, you could speak to your tutor (if you have one) or your supervisor if you prefer.

### **What are the possible benefits of taking part?**

As a client, it is possible that you may welcome the opportunity to share and express your views and experiences with other service users and professionals. By taking part, you will be contributing to an under-researched but important aspect of the therapeutic relationship and which, I hope, will benefit service users in the future and go on to inform, or evoke, further discussion in the profession.

### **Will my taking part in the study be kept confidential?**

As a researcher undertaking an M.A. in Counselling Studies programme at the University of Chester, I have to follow strict laws regarding the Data Protection Act 1998. I work to the BACP Ethical Framework for Good Practice in Counselling and Psychotherapy and to the Ethical Guidelines for Researching Counselling and Psychotherapy (Bond, 2004). Participants' confidentiality will be protected at all times, and all personal data will be stored securely and presented anonymously. In line with University of Chester policy all data will be kept for five years by the researcher and then destroyed.

### **What will happen to the results of this research study?**

The analysed data will be presented and made available in the form of a dissertation which will be kept at the University of Chester for reference and may be made available electronically. Without further consent the material may also be used in conference presentations or published research journals. All information gathered from participants will remain anonymous.

### **What if something goes wrong?**

If you wish to complain or have any concerns about any aspect of the way you have been approached or treated during the course of this study, please contact:  
(email).

If you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence then you may have grounds for legal action, but you may have to pay for this.

**Who may I contact for further information?**

If you would like more information about the research or wish to query anything in this information leaflet before you decide whether or not you would be willing to take part, please contact: Alison Trott on: (email and phone number) and I will be happy to discuss this in more detail.

**Please complete the survey using the link –**

**(link)**

***Thank you for reading this information leaflet***

**If you are in need of further support, a list of qualified counsellors/therapists can be obtained through the following websites:**

*The British Association of Counselling & Psychotherapy (BACP)*

<http://www.itsgoodtotalk.org.uk/therapists/>

*The British Association for Behavioural and Cognitive Psychotherapies (BABCP)*

<http://www.cbtregisteruk.com/Default.aspx>

*The UK Council for Psychotherapy (UKCP)*

<http://members.psychotherapy.org.uk/find-a-therapist/>

*Counselling Directory*

<http://www.counselling-directory.org.uk/>

*The British Psychological Society (BPS)*

<http://www.bps.org.uk/psychology-public/find-psychologist/find-psychologist>

## APPENDIX H

### Survey Monkey – Sample Research Questionnaire

#### Social Class and the Counselling Relationship

##### Information

It is a requirement of the University of Chester that I obtain participants' informed consent. Completing and returning the questionnaire will indicate that you have read and fully understood the information provided on the information leaflet that was attached to the email you received linking you to this study, that you are aware of the implications of taking part, that you have had the opportunity to ask questions should you need anything clarifying.

Before participating in this study please ensure you read the information leaflet. If you have lost this leaflet please do contact me for a copy to ensure you are aware of the purpose of this study and are fully informed about issues such as data protection, confidentiality, risks, benefits, etc. Additionally, if you have any questions or need anything clarifying please do not hesitate to contact me ( ) before submitting the questionnaire.

#### 1. Please indicate your age group

- ☐ 18-25 years
- ☐ 26-35 years
- ☒ 36-50 years
- ☐ 51-65 years
- ☐ 65 and over

#### 2. What is your gender?

- ☒ Female
- ☐ Male

#### 3. Are you a trainee counsellor/psychotherapist or psychologist?

- ☐ Yes
- ☐ No

#### 4. Are you a qualified counsellor/psychotherapist or psychologist?

- ☒ Yes
- ☐ No

**5. Are you in supervised practice?**

☒ Yes

☐ No

**6. If you are qualified, how long have you been in practice? (Please indicate years and months)**

**7. How long ago did you last have any personal therapy? (Please indicate in years and months)**

**8. What was the gender of your last therapist?**

☐ Female

☒ Male

**9. How long were you in personal therapy for at that time? (Please indicate in years and months)**

**10. Are you currently in personal therapy?**

☐ Yes

☒ No

**11. Please indicate which professional organisation you are a member of, (e.g., BACP, UKCP etc).**

**12. How would you define social class (please explain as fully as you can)?**

**13. If social class were divided into the following five categories, which category would you place yourself in (please tick the one you think most applies to you)?**

Upper middle

Lower middle

Upper working

Lower working

	Upper class	class	Class	class	class
My social class is...	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

**14. Do you have any additional comments you would like to add in response to Question 14?**

**15. What do you think determines your social class (please tick all that apply)?**

- ☐ Your job
- ☐ Household income
- ☐ In receipt of benefits
- ☐ Whether you rent your accommodation
- ☐ Your material possessions
- ☒ Where you live
- ☐ Your family's values
- ☒ Your education
- ☒ Other (please specify)

**16. Do you have any additional comments you wish to add in response to Question 16?**

**17. When you have had personal therapy, into which category would you have put your therapist?**

	Upper class	Upper middle class	Lower middle class	Upper working class	Lower working class
My therapist was...	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Other (please specify)

**18. Do you have any additional comments you would wish to add in response to Question 18?**

**19. On which basis have you made this judgement about your therapist?**

- ☒ Their overall appearance
- ☒ The way they spoke
- ☐ The language they used
- ☒ Their job
- ☐ Their knowledge
- ☒ Other (please specify)

their house

**20. Do you have any additional comments you wish to add in response to Question 20?**

**21. In terms of social class, in what ways did you think your therapist was different or similar to you (please describe as fully as you can)?**

**22. Were you aware of social class differences/similarities between you and your counsellor, and if so, in what way(s) did you experience this/these? (Please describe, if you can, as fully as possible)**

**23. In what ways did social class affect your counselling relationship? (Please describe as fully as you can)**

**24. Was social class discussed at any point during the time you were undergoing personal therapy and, if so, how did this impact upon the therapeutic relationship?**

**25. In relation to your therapist, at the beginning of counselling, did you feel ...**

	Inferior				Equal					Superior
Please rate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**26. In relation to your therapist, at the end of counselling, did you feel ...**

	Inferior				Equal					Superior
Please rate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**27. If this changed, what do you think it was that enabled this change? (Please describe as fully as you can)**

**28. If you had (or were to have had) a counsellor of the same social class as you, how did this affect (or how might this have affected) the counselling relationship? (Tick all the boxes that you think apply to you).**

- ☐ There was (or would be) increased trust
- ☒ I felt (would feel) safer
- ☒ I could open up (would open up) and be more honest
- ☐ There was (or would be) more understanding
- ☐ The counsellor could (or would be better able to) identify with me
- ☒ Other (please specify)

**29. If you have ticked any boxes in Question 29, could you please explain your reasons more fully.**

**30. How important is it to you that your counsellor was of the same social class as yourself? (Please indicate by putting a number from 0 – 10 in the box)**

	Very unimportant									Very important
Please rate	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**31. Do you have any other thoughts about how social class affected your counselling relationship?**

**32. Were you aware of your social class when growing up and, if so, please explain what thoughts you have about this.**

**33. Is there anything else you would like to add to any of the above, or anything else you would like to say that you think is relevant to this study? (If so, please write below)**

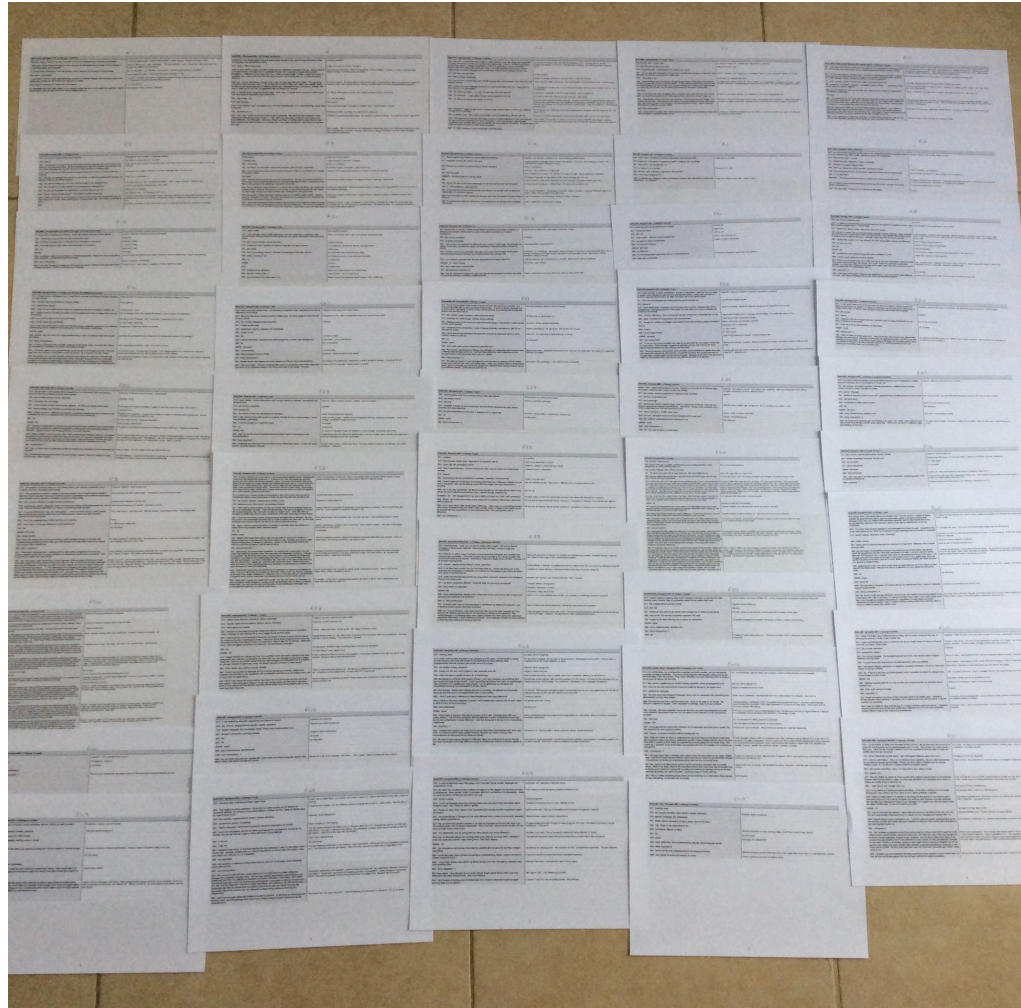
[Click here to complete the survey](#)

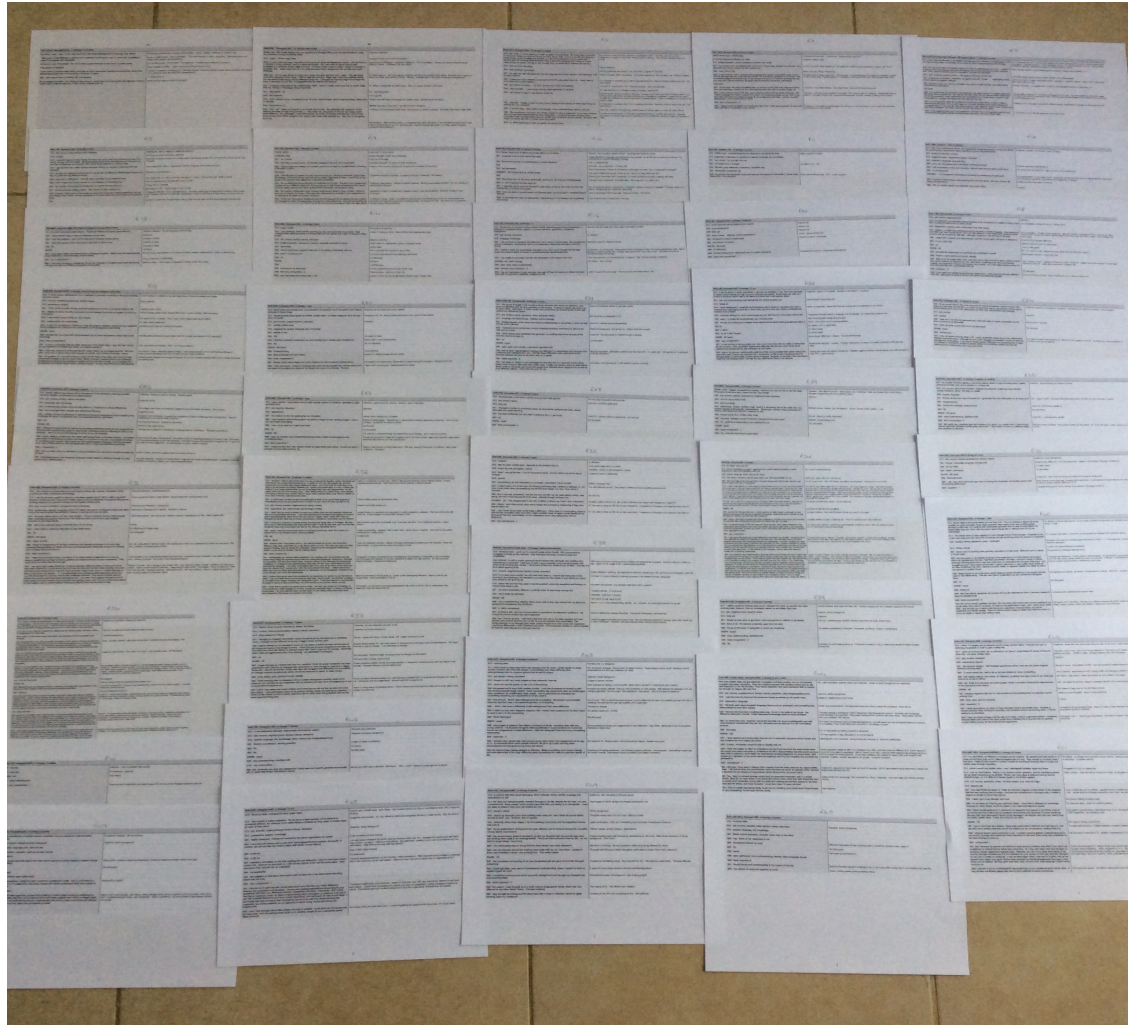
Powered by **SurveyMonkey**  
Check out our [sample surveys](#) and create your own now!



## APPENDIX I

### Individual Questionnaires with my Initial Codes

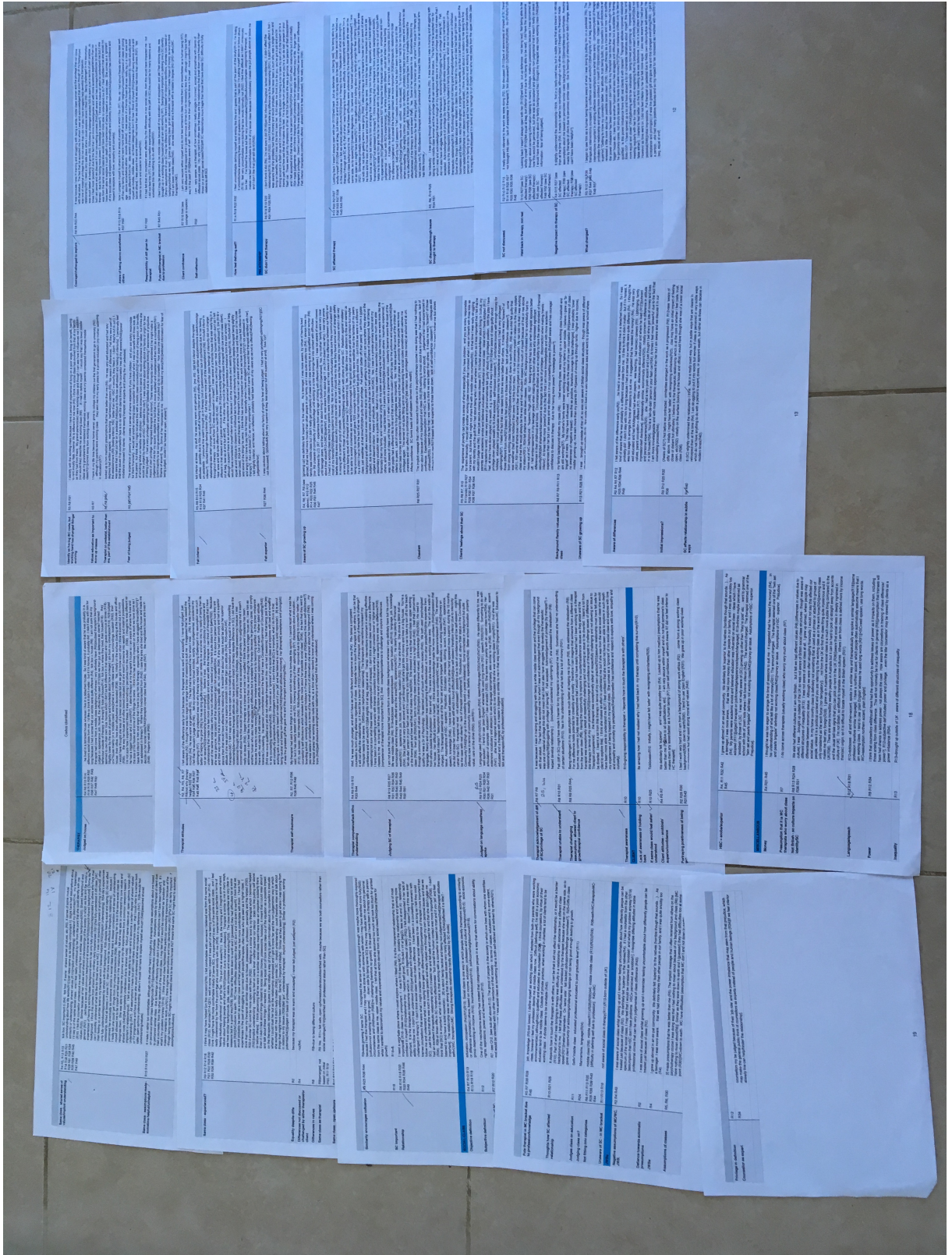




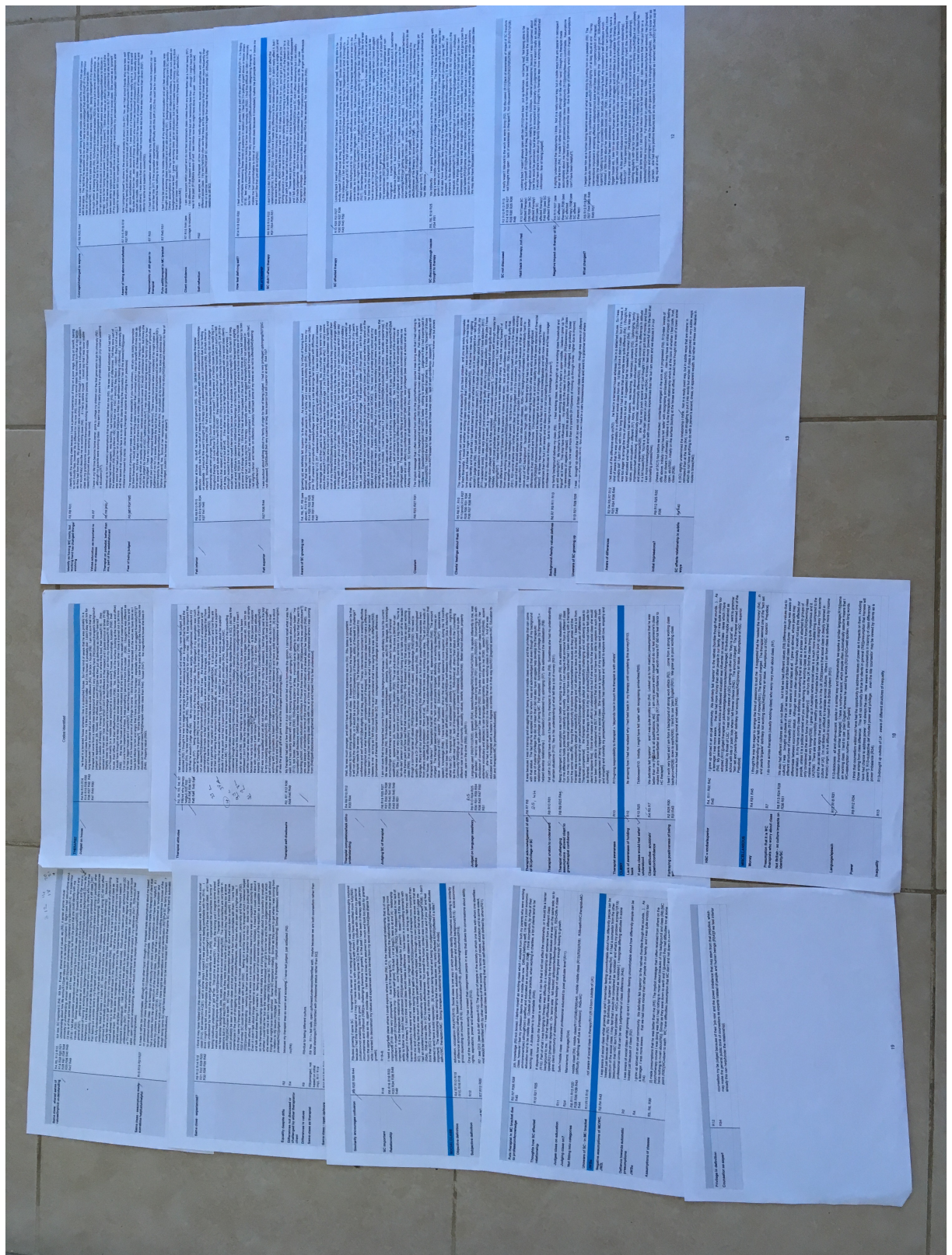


# APPENDIX J

## Initial Themes Identified







## APPENDIX K

### Primary, Secondary and Tertiary Themes

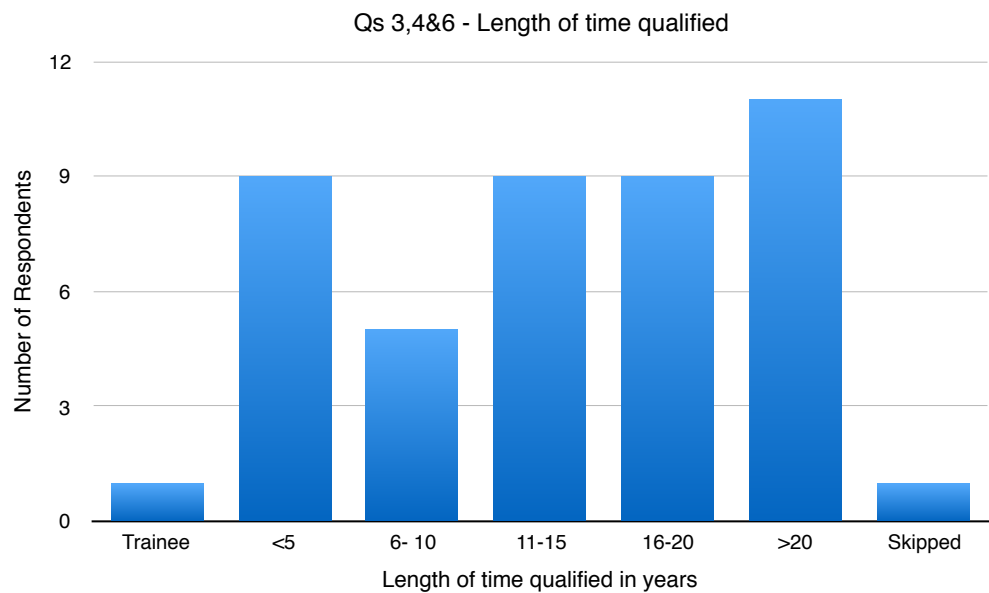
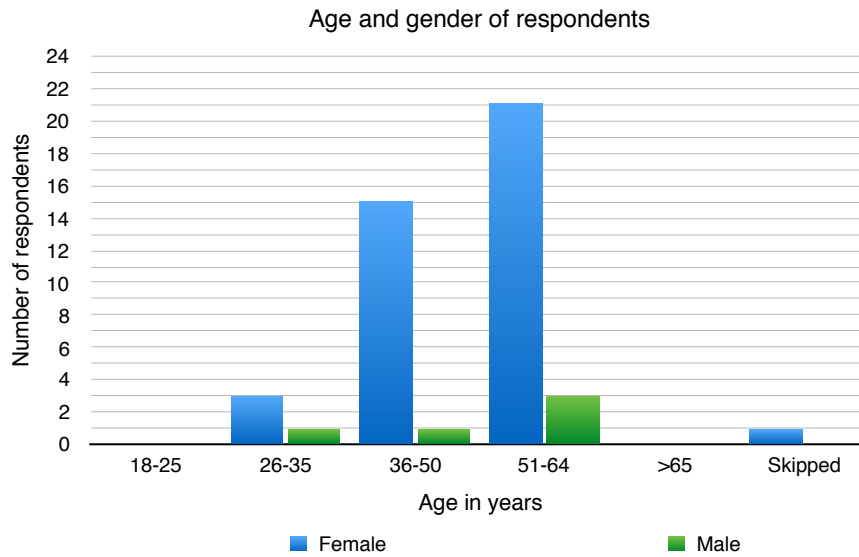
TO WHAT EXTENT DO PERCEIVED DIFFERENCES IN SOCIAL CLASS BETWEEN CLIENT AND THERAPIST IMPACT UPON THE THERAPEUTIC RELATIONSHIP?

1. Social class as a facilitative aspect of therapy:
  - SC discussed/through issues brought to therapy
  - SC shared sense of value/implicit understanding
  - Same class: open up/more understanding
2. Social class – its negative impact on therapy:
  - SC not discussed
  - Same class: Assumptions made
  - Same class: Collusion
  - Different class: Clients' fear of being judged/held back/not real
  - Difficulties experienced
3. Clients' feelings about their therapist
  - Judgments (Judged on house, appearance, judging SC of therapist (similarities/differences), language used/speech, putting therapist on pedestal, initial impressions
  - Therapist self-disclosure
  - Therapist attitudes
  - Therapist competence
  - Therapist acknowledgement/awareness of difference
  - Therapist challenging assumptions
4. Clients' feelings about themselves:
  - Inferior, superior, confident, low self esteem
  - Clients' feelings about their SC/how feel defining self?
  - Clients' awareness of SC/of being above-below others
  - Clients' having courage to explore/challenge themselves
5. Clients' feelings about the therapeutic relationship
6. Classism
7. What changed?

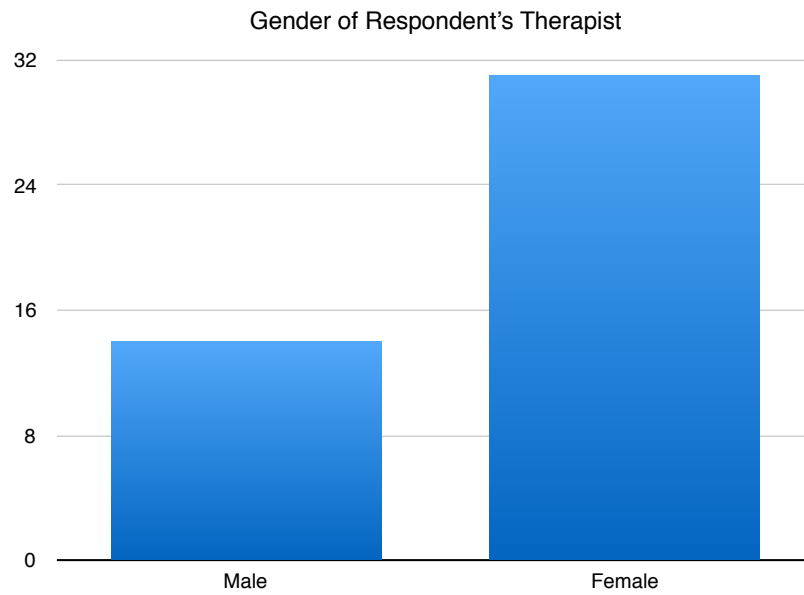
## APPENDIX L

### Respondents' Socio-demographic Data

Q1/2. Age and gender of respondents



Q.8 Gender of Therapist





# APPENDIX M

## Analysing and Evaluating the Data

The image shows a collection of data analysis sheets. The left side features three sheets with tables containing columns for 'Year', 'Month', 'Day', 'Time', 'Location', 'Status', 'Priority', 'Severity', 'Impact', 'Risk', 'Cost', 'Benefit', 'Value', 'Score', 'Rank', 'Index', 'Category', 'Sub-category', 'Item', 'Description', 'Notes', 'Comments', 'Actions', 'Responsible', 'Due Date', 'Progress', 'Status', 'Comments', 'Actions', 'Responsible', 'Due Date', 'Progress'. The right side features three sheets with tables containing columns for 'Year', 'Month', 'Day', 'Time', 'Location', 'Status', 'Priority', 'Severity', 'Impact', 'Risk', 'Cost', 'Benefit', 'Value', 'Score', 'Rank', 'Index', 'Category', 'Sub-category', 'Item', 'Description', 'Notes', 'Comments', 'Actions', 'Responsible', 'Due Date', 'Progress', 'Status', 'Comments', 'Actions', 'Responsible', 'Due Date', 'Progress'. Handwritten notes and calculations are visible on the papers.